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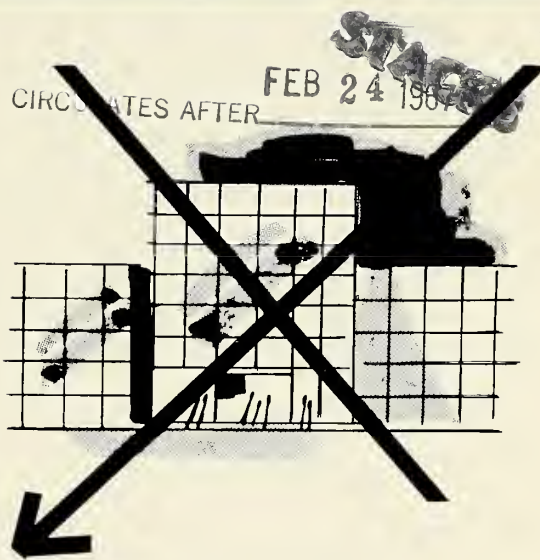
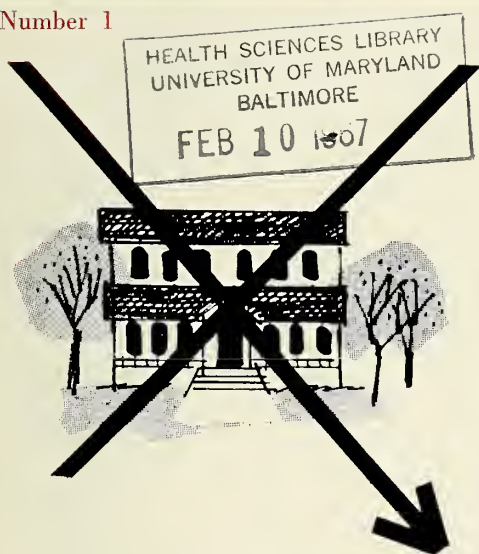
IMJ

Illinois Medical Journal

OFFICIAL JOURNAL OF THE ILLINOIS STATE MEDICAL SOCIETY

ne 131, Number 1

January, 1967



ECF

a cross between a nursing home and a hospital

**How Extended Care Benefits
of Medicare Affect Physician
and His Practice . . . page 45**

Complete Table of Contents—see Page 2

arrest diarrhea



LOMOTIL[®]

tablets
liquid

Each tablet and each 5 cc. of liquid contains:
 diphenoxylate hydrochloride 2.5 mg.
 (Warning: May be habit forming)
 atropine sulfate 0.025 mg.

in gastroenteritis, acute infections

Effectiveness—Physiologic evidence indicates that Lomotil acts directly on the smooth muscle of the bowel to lower motility and control diarrhea. This action is unsurpassed in promptness and efficiency.

Convenience—Lomotil is available as small, easily carried, virtually tasteless tablets and as a pleasant, fruit-flavored liquid.







Versatility—The therapeutic efficiency, safety and convenience of Lomotil may be used to advantage alone or adjunctively in diarrhea associated with:


- Functional hypermotility
- Irritable bowel
- Acute infections
- Gastroenteritis and colitis
- Malabsorption syndrome
- Regional enteritis
- Ileostomy
- Ulcerative colitis
- Food poisoning
- Drug therapy

*For correct therapeutic effect
 Rx correct therapeutic dosage*

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp. t.i.d. (3 mg.) 
 6-12 mo. . ½ tsp. q.i.d. (4 mg.) 
 1-2 yr. . . ½ tsp. 5 times daily (5 mg.) 
 2-5 yr. . . 1 tsp. t.i.d. (6 mg.) 
 5-8 yr. . . 1 tsp. q.i.d. (8 mg.) 
 8-12 yr. . . 1 tsp. 5 times daily (10 mg.) 

Adults: . . 2 tsp. 5 times daily (20 mg.) 
 (or 2 tablets q.i.d.)

*Based on 4 cc. per teaspoonful.

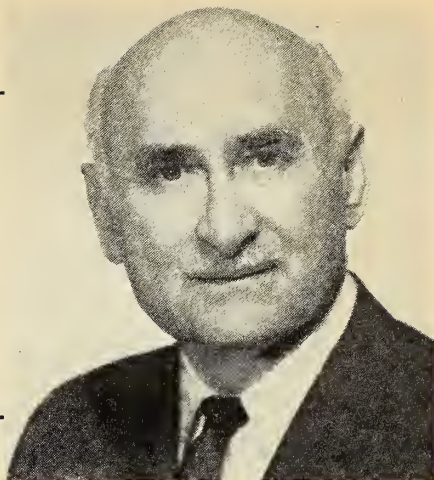
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is a Federally exempt narcotic preparation of very low addictive potential. Lomotil should be kept out of reach of children since accidental overdosage may cause severe respiratory depression. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

SEARLE Research in the Service of Medicine

The president's page



Caesar Portes, M.D.

Medicine and Medical Organization

Medicine has sold its birthright. The medical profession, the doctors, have turned over their reins of running medical organizations to non-medical personnel. It's about time that we realize that medicine must once again take hold of the business and management of hospitals, clinics, projects that the government is proposing, etc., etc.

Let us take the hospital for one example. There has been a time in the past that a doctor was the administrator. Changes have taken place because it was felt that the doctor might be using this power to his own advantage. It was then decided that a non-medical man should be the administrator of the hospital. In my opinion, this is far from good. A hospital is a medical facility. It deals with service to sick people. Of course, it has certain business aspects. However, in the main the doctor should be at the helm—both administrator and medical director, and be provided help in the business office and in other areas such as house-keeping, dietary, etc., etc. These people to act as his assistants.

Doctors are a special kind of breed. They have certain feelings of self-sufficiency. They feel that they should not be directed or given orders by someone who is not aware of medicine as much as they are; who can talk, who can reason, who can argue with a doctor but another doctor? I feel the same situation exists with nursing. Nurses will take certain orders from the

doctor but will hesitate to accept the opinion of lay people. It is for this reason that I feel that the head of the hospital should be a medical man and have under him assistants who deal with the business aspect of a hospital.

Another example in the relinquishing of the rights of medicine is illustrated especially in these federal projects. For example, in this program for heart, cancer and stroke. The President's "Great Society" movement has been turning to the nation's universities for new ideas and creative leadership in the health team in Washington.

Ordinarily the advice and impetus for innovation should come from amongst those who are now interested in providing health care, the medical practitioners, state and local public health departments, etc. But, the administration in Washington feels that these groups have been defenders of tradition and are resistant to change. Consequently, the government has been turning more to the academicians or to the universities.

Secretary Gardner and his team are now looking to the universities for creative leadership not only in the fields of research and training but in the field of giving health service as well. They feel that universities, not just medical schools, can be stimulated to produce ideas for solving the problems of health manpower shortage, in-

(Continued on page 112)

Look how many ways

Thorazine®

brand of

chlorpromazine

can help


	Tranquilizer	Potentiator	Antiemetic
Agitation	●		
Alcoholism	●		●
Anxiety	●		
Cancer patients	●	●	●
Severe neurodermatitis	●		
Drug addiction withdrawal symptoms	●		●
Emotional disturbances (moderate to severe)	●		
Nausea & vomiting	●		●
Neurological disorders	●		
Obstetrics	●	●	●
Pain	●	●	●
Pediatrics	●	●	●
Porphyria	●	●	
Psychiatric disorders	●		
Hiccups—refractory	●		
Senile agitation	●		
Surgery	●	●	●
Tetanus	●	●	

'Thorazine' is useful as a specific adjuvant in the above named conditions.

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. **Contraindications:** Comatose states or the presence of large amounts of C.N.S. depressants. **Precautions:** Potentiation of C.N.S. depressants may occur (reduce dosage of C.N.S. depressants when used concomitantly). Antiemetic effect may mask other conditions. Possibility of drowsiness should be borne in mind for patients who drive cars, etc. In pregnancy, use only when necessary to the welfare of the patient. **Side Effects:** Occasionally transitory drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; mild fever; hypotensive effects, sometimes severe with

I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

Smith Kline & French Laboratories 



Robert L. Richards Resigns to Become President of Confectioners Association

Robert L. Richards has resigned his position as executive administrator of the Illinois State Medical Society to become president of the National Confectioners Association of the United States. Effective date of the resignation is expected to be early in February.

Richards came to the Society in 1960 as a result of a nationwide search for an executive administrator as recommended by management consultants, Rogers, Slade and Hill of New York. He is also the first executive director of the Illinois Association of the Professions which was established in 1963 and represents eight professional organizations and their 40,000 members in the state of Illinois.

Before coming to Illinois, Richards served as the first executive director of the American Society of Internal Medicine in San Francisco, Calif. From 1947 to 1958 he was with the Pennsylvania Medical Society.

The Chairman of the Board of Trustees, in consultation with the Executive Committee, has appointed a special Ad Hoc Committee which is to "seek, interview and recommend to the Board of Trustees a successor to Mr. Richards."

This committee consists of George F. Lull, M.D., chairman, Harlan English, M.D., Burtis E. Montgomery, M.D., Edward A. Piszczek, M.D., and Leo P. A. Sweeney, M.D.

Ex-officio members are William E. Adams, M.D., Walter Bornemeier, M.D., Newton DuPuy, M.D., Arthur F. Goodyear, M.D., Caesar Portes, M.D., and Jacob E. Reisch, M.D.

Persons interested in applying for the position of Executive Administrator of the Illinois State Medical Society are requested to write George F. Lull, M.D., Apt. 1230, 400 E. Randolph St., Chicago 60601.

Judges Selected for Annual Medical Journalism Competition

Judges have been named for the Illinois State Medical Society's third annual state-wide medical journalism awards competition. The judging will be done this month, with the winners announced at an awards dinner Mar. 11 at the Ambassador West Hotel in Chicago.

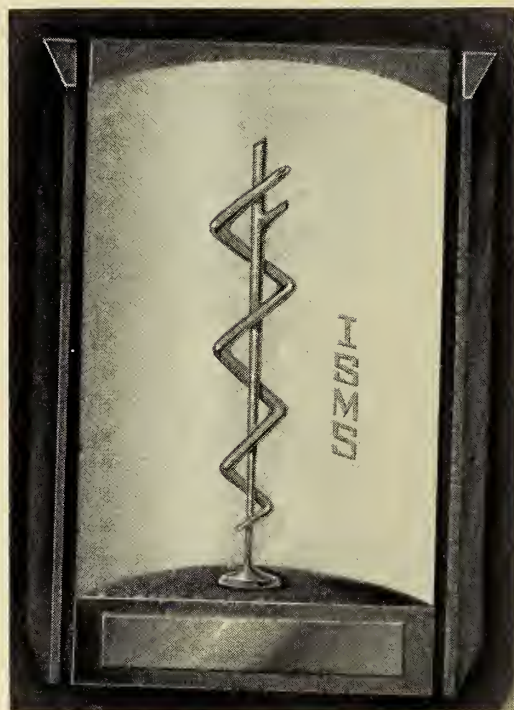
Dr. Leo P. A. Sweeney, chairman of the ISMS Public Relations Committee, said purpose of the awards is to "acknowledge achievement in communications contributing to a better understanding of medicine and health in Illinois."

The judges, provided by the Publicity Club of Chicago, include:

Mrs. Dene Raterman Murray, executive director, American Association of Medical Assistants; Nancy B. Newman, Public Relations Office, University of Chicago Hospitals and Clinics; Bud Light, director of public relations and special events, University of Illinois Medical Center; Elaine Falk Katz, Chicago; Jack W. Righeimer, assistant director of public information, University of Illinois Medical Center; James L. Stott, director of development and public relations, LaGrange Community Memorial General Hospital; Lee Feldman, Cooper & Golin, Inc., Chicago; Mrs. Sara Barr Cohen, publicity director, American College of Surgeons; and Otha Linton, director of public relations, American College of Radiology.

Four physicians will also be judges. They are Dr. Lee F. Winkler, Springfield, a member of the ISMS Public Relations Committee; Dr. Robert Mendelsohn, Chicago; Dr. Catherine L. Dobson, Chicago; and Dr. J. H. Skom, Chicago.

Judges will evaluate entries in four categories—daily newspapers, weekly newspapers, radio and television. Judging is on the



basis of accuracy, creative quality, impact of message, and public interest.

All winning entries qualify to be entered in the American Medical Association's medical journalism awards competition, which offers a cash prize of \$1,000 for winning entries in each category.

Last year's winners were the Chicago Daily News; the Chicago Sun-Times; the Chicago Tribune; the Illinois State Register (Springfield); The Southern Illinoisan (Carbondale); the Cuba Journal; the Highland Park News; The Peacock Newspapers; radio stations WBBM, WGN, and WIND, all of Chicago; WKRS, Waukegan; WTAX, Springfield; and television stations WBBM-TV and WMAQ-TV, Chicago.

An Appraisal Of The Illinois State Medical Society By Its Members

By ROBERT D. BEST AND HARRY W. O'NEILL

The Illinois State Medical Society, during the latter part of last year, retained Opinion Research Corporation of Princeton, N. J., to conduct a comprehensive survey among its membership so that an objective appraisal of the Society, its leadership, and its activities could be obtained. This report presents some of the major findings of the survey.

The Research

The physicians interviewed were selected by probability methods from the most recent county medical society membership lists. Two samples were selected, one for personal interview and one for interview by way of a mail questionnaire. In all, 200 physicians were interviewed in person and 945 completed usable mail questionnaires were returned.* The interviewing was conducted during the early part of 1966.

The questionnaires were prepared after preliminary, semi-structured interviews with a number of physicians throughout the state and discussions with members of the Society's Board of Trustees and staff. The final versions of the questionnaires were then reviewed in detail by the Executive Committee of the Board of Trustees and key staff personnel.

The complete results of the study have been reported verbally before the House of Delegates at its June meeting and have been presented to the Society in a detailed 165-

page written document. This article highlights only some of the most important findings.

Highlights of the Study

The principal findings of the study can be summarized as follows:

- Just over half of Illinois physicians claim their Society membership is valuable, although another 43% say it is not very valuable.
- However, most physicians claim to make little use of Society services.
- Few physicians have played an active role in the Society, but almost half say they would be willing to serve if requested.
- Although the appraisal of the Society's past legislative effectiveness is only lukewarm, most physicians believe legislative activities should be stepped up.
- Physicians view the Society's income as adequate for its expected activities, but over half the members believe the amount of dues to be too high.
- On balance, the Society's leadership—both paid and voluntary—is favorably evaluated.
- Physicians regard the public image of medicine in Illinois as quite favorable.
- Physicians believe that the public is ill-informed about a number of important topics, chief of which are the amount of charity work done by physicians, the hours physicians work, and hospital charges.

*Complete details of the sampling and interviewing procedures used are available upon request from Opinion Research Corporation, Princeton, N. J.

- Most physicians contend that the Society is not responsive in advance to social and political change, but merely reacts after the fact.

Value of the Illinois State Medical Society

Fifty-three per cent of Illinois physicians characterize their membership in the State Medical Society at least fairly valuable, while another 43% regard it as not very valuable. Of some significance is the fact that regard for the value of membership is poorest among the younger physicians, that is, those under age 40. Almost three-fourths of the membership, however, claim to make little or no use of the various services available from the Society. (See Table 1.)

Table 1
Use Made of Services

	Illinois Physicians
Great deal	4%
Fair amount	21
Very little or none	73
No opinion	2
(Percentage base)	(1145)

Chief among the reasons for not using the Society's services is simply a lack of awareness of just what services are offered. Often this is coupled with the explanation that there just is not time to keep abreast of the Society and its various activities. There is also some feeling that the services offered simply duplicate those available from other sources, such as the AMA or specialty societies. Apparently there is need for a critical review of both the services offered and the means by which the services and the benefits derived therefrom are made known to the membership.

More attention by the Society to protecting physicians' right to practice medicine in an open competitive system might enhance the Society's value in the eyes of many members, particularly the younger physicians. Most Illinois physicians believe that the average physician has not been very active in protecting his right to practice medicine in an open free enterprise situation. The majority believe, however, that the individual physician's willingness to act in this regard is on the increase. Greater Society effort focused on this problem would seem to be welcomed by the membership.

Appraisal of Specific Activities and Services

On specific evaluations in several key areas, the Society's performance rates quite well. (See Table 2.)

Table 2
Rating of the Performance of the State Medical Society in Several Key Areas

	Good	Fair	Poor	No Opinion
Elevating standards of medical education	49%	24	8	19
Preserving free enterprise system of practice	48%	23	18	11
Providing information on government proposals affecting medicine	47%	28	13	12
Providing information on personal insurance plans	46%	31	7	16
Increasing the supply of doctors	27%	19	26	28
Providing information on business aspects of practice	23%	38	21	18
Providing information on third party insurance plans	16%	24	17	43
(Percentage base: 200)				

On the whole, the ratings shown in the table above are satisfactory. The two areas that receive the largest amount of criticism are the Society's efforts to increase the supply of doctors and activities relating to providing the physician with information on the business aspects of his medical practice.

An important function of the State Society is its lobbying and legislative activities. This is a sensitive area of activity. It generates more direct criticism from the membership than does any other aspect of the Society, and its effectiveness to date is not judged outstanding. Nevertheless, physicians recognize that political action on the part of the Society is necessary, and most believe that the Society should step up its legislative activities.

Communicating effectively with a busy membership who already receive a large, continuing flow of literature, journals, and the like, is an extremely difficult task. However, most physicians express an interest in the possibility of receiving several special periodic newsletters that would summarize up-to-date information in a particular area of interest, such as medical and scientific advances, activities, political and public affairs, business aspects of medical practice.

Most physicians regard the annual convention as worth the cost of attendance and they view the convention as a very good means of keeping abreast of new scientific and medical advances and current information of importance to the medical community. Only about a fifth of Illinois physicians say they have never attended an annual convention of the State Medical Society, and most of them offer lack of time as the reason rather than particular criticisms of the convention and its conduct.

Dues

Most members believe that the State Medical Society has an adequate income for its expected activities. In responding to a rather general question on the adequacy of budget, virtually no physician is so critical as to claim that the income of the State Medical Society is too high. About a fourth of the members, however, reserve judgment, probably because they have a vague idea of exactly what the income is. If the Society were to feel a budget squeeze, its leadership faces a rather formidable task to convince the membership of the need for increased income in rather concrete terms. As to the Society's dues structure, over half the membership regards it as equitable to all members. There is some cause for concern, however, as 17% of the membership believe inequities exist and over a fourth indicate uncertainty by withholding their opinion. (See Table 3.)

Table 3
Fairness of Dues Structure

Dues structure is fair to all	55%
There are some inequities	17
No opinion	28
(Percentage base)	(200)

Those who are critical of the dues structure focus mainly on two points. Dues are considered out of line for physicians on both ends of the age spectrum, the young and the retired. Secondly, opinion as to the equity of the dues structure depends on what the physician believes he is receiving from the Society. Several typical comments follow:

"The older man shouldn't have to pay so much—older people should be able to be on a semi-retired list and not have to pay full dues."

"Dues are unfair to the young doctors who are in their first few years of practice and just getting going."

"Chicago men get more for their money, such as they have a County hospital to help the public aid patients and indigents. We get no help in this respect."

"Doctors downstate use the facilities of the State Medical Society a great deal more than the physicians in Chicago."

Evaluation of Paid and Voluntary Leadership

Both the paid and the voluntary leadership of the State Medical Society are reasonably well regarded. The performance of the paid staff and the voluntary physician leadership receive about the same appraisal, suggesting that the membership tends to view the Society's leadership as a single entity—not as two separate bodies. Credit or blame for the actions of one probably reflects on the other as well. (See Table 4.)

Table 4
Rating of Leadership

	Excellent	Good	Fair	Poor	No Opinion
Executive Administrator	15%	29	18	9	29
Paid staff	14%	32	19	9	26
Physician leadership	12%	31	24	14	19
Board of Trustees	9%	32	26	14	19

(Percentage base: 1145)

The major criticism made of the Society's leadership is that membership on the Board of Trustees is not changed often enough. Only about a fourth of the membership feel that the Trustees are changed sufficiently often, while four members in 10 believe that Board members serve for too long a period of time. Of course, any organization faces the problem of encouraging members to take an active role within the organization. What often happens is that only a handful of the membership volunteer the time and effort necessary to serve. These people, therefore, tend to be called on with considerable frequency for a variety of organization activities. The leadership of the organization should make an effort to seek out and encourage new blood to serve on the various boards and committees of the Society. Such action seems indicated by the fact that almost half of the membership testifies to being willing to serve if they

were requested to do so by the Society's president. While there might be some exaggeration in this stated commitment, there does appear to be more willingness to serve within the membership than has been tapped to date. Efforts to increase member involvement in meaningful assignments would have high payoff value, because with increased involvement comes a greater use of the Society's services and stronger support of the Society's activities.

Image of the Illinois State Medical Society

Physicians were presented with 19 statements that might be used to describe the Illinois State Medical Society—some favorable, some unfavorable—and asked to select those that, in their opinion, apply to the Society. Most frequently selected as descriptive of the Illinois State Medical Society, and underlying what is probably the most severe problem facing the Society's leadership, is the statement "too many physicians are apathetic about the Society." Close to three-fourths of the membership hold this view. This is a serious situation and one, of course, that is reflected in questions pertaining to how the membership views the value of the Society and its services. The only other negative characteristic attributed to the Society by at least a fourth of the members is the belief in the existence of a serious division between Chicago and downstate members. It is the downstate members particularly who sense the split.

On the favorable side, the Society's efforts to serve the needs of all physicians is the most often selected characteristic. Over four members in 10 believe this to be the case. However, it is the older physician much more so than the younger who holds this view. Thus, there must be a continued, if not increased, effort to reach the younger physicians because, as noted earlier, it is these members who are more prone to question the value of membership in the Society and to make less use of the available services.

Public Image of Medicine in Illinois as Seen by the Medical Profession

Over three-fourths of Illinois physicians

believe that medicine enjoys at least a fairly good reputation throughout the State. (See Table 5.)

Table 5
Physicians' View of Public Image of Medicine in Illinois

Public image of medicine is . . .	
Very good	17%
Fairly good	61
Not too good	14
Poor	6
No opinion	2
(Percentage base)	(200)

} 78%
} 20

Physicians see themselves as the most effective promoters of a good public image of medicine. Physicians were asked to evaluate the kind of job done to promote such an image by the AMA, the Illinois State Medical Society, their County Medical Society, and the individual physician himself. The individual physician receives substantially the most credit; the AMA by far the least credit. The State Medical Society falls between these two, with evenly divided reactions as to the kind of job it has done to date in boosting medicine's public image. (See Table 6.)

Table 6
Rating of the Job Done to Promote a Good Public Image of Medicine

	Illinois			
	Individual Physician	County Medical Society	State Medical Society	American Medical Association
Excellent	16%	12%	11%	9%
Good	42	33	30	25
Fair	24	25	29	33
Poor	10	15	14	32
No Opinion	8	15	16	1
(Percentage base: 200)				

} 58% } 45% } 41% } 34%
} 34 } 40 } 43 } 65

So far as improving the public image of medicine is concerned, physicians believe that better physician-patient relations is the most promising route to follow. This, of course, is in keeping with the opinion that the individual physician has done the best job to date. Whether the public image of

medicine is to be improved by efforts of the individual physician or the State Medical Society, there are several problem areas that physicians believe the public is rather ill-informed about and that should receive some specific public relations attention. The most frequently mentioned are these: the amount of charity work done by the average physician, the hours worked by physicians, and hospital charges.

A rather serious problem which faces the State Medical Society is the belief on the part of somewhat over six physicians in 10 that the State Medical Society is not responsive in advance to trends of social and political change. On the whole, Illinois physicians regard their Society as reacting after the fact. While the passage of Medicare was not the responsibility of the Illinois State Medical Society, nevertheless this particular piece of legislation is cited as the shining example of organized medicine's inability to be responsive in advance to social change. Many doctors seem not to react so violently to Medicare-type plans and legislation as to the fact that the medical profession seems to have reacted to rather than guided developments. The responsibility of the State Medical Society is to continually look ahead and help the membership anticipate and prepare for the future. When painful change is necessary, those affected will accept it better if they have had a hand in shaping and implementing it rather than merely having it thrust upon them.

Recommendations Stemming From the Research

Following are some of the recommendations suggested by the research that might be taken under advisement by both the leadership and members of the Illinois State Medical Society.

1. Apathy, more than large numbers of unhappy or dissatisfied members, seems to be the Society's major problem. And it should be remembered that apathetic members can be more harmful than involved but highly critical members. Apathetic members remain distant to the Society and its needs and problems. They offer the leadership no feedback—critical or supportive.

Members, therefore, need a very explicit statement of the goals and purposes of the Illinois State Medical Society. They need a clear understanding of the Society's relationship with other professional medical organizations and what the unique role of the Society is. Furthermore, there is need to increase member awareness of the activities and services of the Society, and to demonstrate to the members how they can benefit from them.

2. Committee membership is an excellent way to broaden the base of membership participation. There would seem to be a fairly large group of members who are willing to participate in the Society but who need to be contacted and encouraged to do so. Spreading committee membership will not only involve more members actively, but will bring the advantages of new blood and fresh ideas to bear on the Society's problems. However, attention should always be paid to the meaningfulness of committee assignments. Tasks should be deemed important and have definite objectives. Continual review of committee assignments is necessary. The aim is to eliminate both "busy work" and deadwood.
3. The Society could benefit from more emphasis on the young physician, more involvement with the physician in his first few years of practice. If the young physician is ignored when he starts to practice in the State, he may be lost to the Society forever. However, the value of the Society can be visibly demonstrated to the young physician, and the chances of establishing a meaningful relationship can be greatly increased. The young physician should be personally contacted early in his career and asked how the Society can assist him. Thus, the relationship begins by the Society helping the young physician and moves to where the established physician has reason to help the Society. This need might logically be carried to where the Society pays increased attention to the students in Illinois medical schools.

4. The Society's legislative story needs to be carried in more detail to the membership as a whole. Members should be kept constantly aware of what the Society is doing at both state and federal level and why it is being done. A periodic legislative newsletter to all members outlining efforts and soliciting reactions might well be considered.
5. Since no level of organized medicine is thought of as doing a particularly good job in promoting a favorable image of medicine, the importance of the individual physician in this regard is considerable. The Illinois State Medical Society, therefore, has a responsibility to help the individual physician in this area, and the physician is looking for help and would welcome it.
6. The establishment of a Task Force to study the future of medicine and the State Society is recommended. Organized medicine is scored by its membership for failing to be socially and politically responsive, for acting only after the fact, for allowing "outsiders" to shape medicine's future. The Society should take steps to reverse this by continual examination of where it is today and where it is going, by looking in depth at such areas as the physician-patient relationship, medicine's changing relationship with government, and relations with allied medical groups.

TASK FORCE APPOINTED

In accordance with Recommendation No. 6, the chairman of the Illinois State Medical Society Board of Trustees, Arthur F. Goodyear, M.D., has appointed a Task Force to Study the Opinion Research Survey. This committee, headed by President-elect Newton DuPuy, M.D., as chairman and William E. Adams, M.D., vice chairman, was scheduled to conduct its first meeting Jan. 13 in Chicago.

The following physicians are members of the Task Force:

Allison L. Burdick, Jr., Chicago; Edward W. Cannady, East St. Louis; Raymond H. Conley, Park Ridge; Keith H. Frankhauser, Avon; Jack Gibbs, Canton; John J. Holland, Galesburg; Mack Hollowell,

Charleston; Jerry Ingalls, Paris; Gerald S. Laros, Moline; William M. Lees, Lincolnwood; George F. Lull, Chicago; Coye C. Mason, Chicago; Kenneth Morris, Waukegan; Maurice Murfin, Decatur; Raymond W. Nemecek, Berwyn; Edward A. Piszczek, Chicago; Norman Powers, Peoria; Jacob E. Reisch, Springfield; Charles N. Salesman, Robinson; Grover L. Seitzinger, Danville; V. P. Siegel, East St. Louis; Burton Soboroff, Chicago; John Steinkamp, Belvidere; Paul W. Sunderland, Gibson City; Leo P. A. Sweeney, Evergreen Park; N. A. Thompson, Eldorado; Paul Van Pernis, Rockford, and Francis W. Young, Chicago.

How Extended Care Benefits of Medicare Affect Physician and His Practice

Dr. Ford Explains New Regulations

By PAT MILLER AND GAYLEN LAIR
*Illinois State Medical Society
Division of Public Relations and Economics*

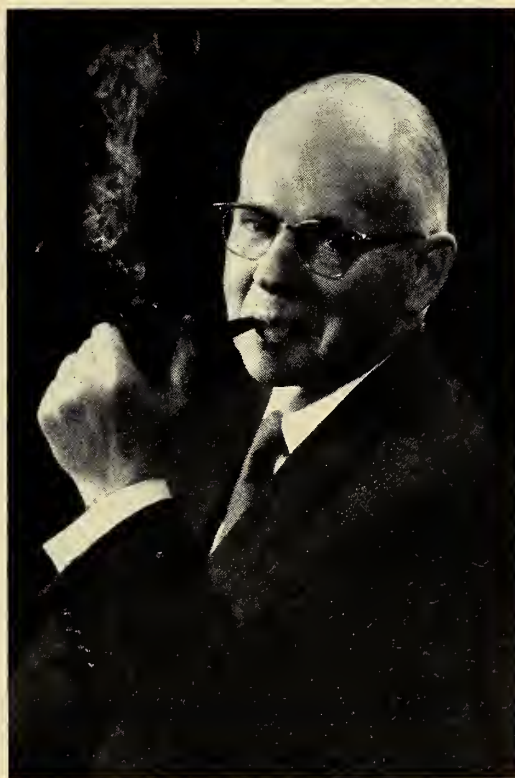
On Jan. 1, 1967, the extended care benefits of Medicare began for the over 65. Although Social Security will only pay this benefit for your older patients, the extended care facility (ECF) is available to all your patients requiring skilled nursing care.

Since longer stays in the hospital and nursing home become more frequent with the older patient, we have asked Dr. William K. Ford, Chairman of the ISMS Committee on Aging, to explain how this new concept will affect the physician and his practice.

Dr. Ford, what is an extended care facility?

An ECF is a new type of health care facility—something of a cross between a hospital and nursing home—for patients who require less intensive care than that of a hospital, yet more skilled and intensive than what is usually available in a nursing home. This care should be relatively short term in comparison to usual long term or custodial care provided in nursing homes.

The new entity is defined by law as “an institution or distinct part of an institution which is primarily engaged in providing to in-patients skilled nursing care and related services for patients who require medical or nursing care or rehabilitation (restorative) services for the injured, disabled, or sick person.” To provide these services under the Medicare program, the facility must meet stringent standards established by P.L. 89-97.



(Fabian Bachrach Photo)
William K. Ford, M.D.

How did the government establish these standards and what do they include?

The standards which must be met to qualify as an ECF were prepared by the Department of Health, Education and Welfare and the Social Security Administration

after considerable discussion with experts in the fields of hospital, nursing home, and medical care. They are considered a "minimum" level so that all ECF's will provide high quality patient care.

The standards cover such diverse fields as compliance with existing state and local laws, patient care, and building specifications.

What services are available to a patient in this facility, Dr. Ford?

According to the law, these services must be provided:

- Nursing care provided by or under the supervision of a registered professional nurse
- Bed and board (Semi-private)
- Restorative (physical, occupational or speech) therapy furnished by the ECF or by others under arrangements made by the facility
- Medical social services
- Drugs, biologicals, supplies, appliances, and equipment usually furnished for patients by the ECF
- Services of an intern or resident-in-training of a hospital with which the facility has a transfer agreement
- Other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement



SKILLED NURSING CARE



RESTORATIVE SERVICES

That sounds great, but what portion of these services will Medicare actually pay?

Medicare will provide a total of 100 days as extended care benefits for each "spell of illness." Medicare will pay the full cost for the first 20 days, with the patient paying \$5 a day for the remaining 80 days.

Medicare will not cover the cost of a private duty nurse, nor the full cost of a private room unless it is medically necessary. Physicians services, of course, are only paid for if the patient has the Part B voluntary portion of Medicare.

Doctor Ford, you mentioned a "spell of illness." What's that?

A "spell of illness" is a period of time during which benefits are payable for in-patient hospital services and ECF services. It does not refer to any particular illness or single stay in a hospital or ECF. A patient's first "spell of illness" begins on the first day after June 30, 1966, that he receives covered in-patient hospital or extended care services. It ends when the patient has not been in any hospital or ECF for 60 consecutive days. Then a new "spell of illness" begins the next time the patient receives covered in-patient hospital or extended care services.

But what if the patient has used up his 100 day benefit and isn't ready to go home?

If the patient has continuing need for ECF care but has exhausted his benefit, Medicare will pay no further benefits since the 60-day requirement still applies. The patient may remain in the facility if it is medically indicated, but he must pay for the services provided through private insurance, other sources, or be eligible for benefits under Title XIX.

Can anyone be admitted to an ECF or is this care only for Medicare and Title XIX patients?

An ECF need not limit its admissions to those over 65. The high quality care to be provided by an ECF is desirable for all age groups so that appropriate use of both the hospital and out-of-hospital services will prevail.

Can all long term care institutions participate in the Medicare program?

Yes, but there are limitations since Medicare does not pay for long term or custodial care. A long term care facility can set aside a "distinct part" of the institution for ECF purposes—provided this "distinct part" meets all the statutory requirements and conditions of participation as required by P. L. 89-97.

How many ECF's will be certified in Illinois?



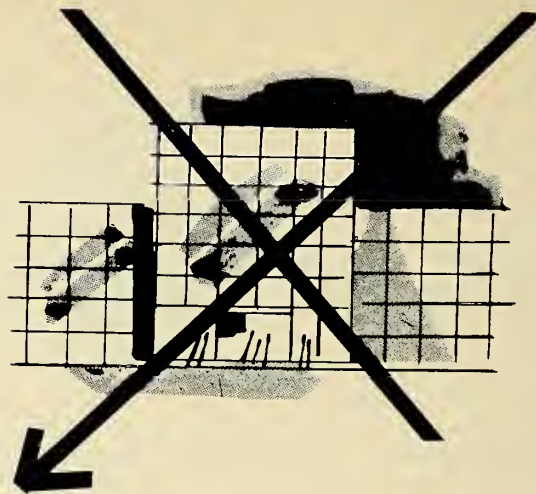
Well, I've checked with Dr. Roger F. Sondag who is chief of the Division of Hospitals and Chronic Illness of the Illinois Department of Public Health. He anticipates only about 20 percent of the 33,000 nursing home beds in Illinois to qualify initially.

Let's go back to the patient over 65—what conditions must he meet in order to qualify for ECF benefits?

Well, first of all, he must have been hospitalized for at least three days after June 30, 1966. Secondly, his admission must be on a doctor's orders within 14 days after discharge from the hospital. The patient must be admitted for further treatment of a condition for which he was hospitalized.

Can a patient go to the ECF he chooses or must it be one that has a transfer agreement with his hospital?

The patient can go to any ECF he



ECF

a cross between a nursing home and a hospital

chooses, regardless of a transfer agreement. By the same token, an ECF can accept patients from any hospital, but it must have a transfer agreement with one participating hospital to qualify. If the ECF has been unable to enter into a transfer agreement with one of the hospitals in its area, it can still qualify for Medicare participation if it can show that an attempt has been made.

Does private insurance provide coverage for the ECF?

That depends on the policy. Some insurance policies provide this coverage now. For example, the major medical group policy available to ISMS members provides "convalescent home" expense following not less than seven days hospital confinement up to a maximum of \$20 per day for a period of 90 days. The broad definition of "convalescent home" would include a stay in an ECF.

As experience is gained in the ECF program, private insurance may extend this benefit.

Does the physician have any obligation to his ECF patients?

Well, Medicare requires that clinical records be kept indicating the admitting diagnoses, patient care plan, and notations on progress. These records must be kept current, dated, and signed. But then, the

doctor must do this anyway for his nursing home patients.

The physician must visit his patient at least once every 30 days and so indicate this on the record. At present, Illinois law requires a doctor to visit his nursing home patient every 90 days, so this would mean closer medical supervision for his ECF patient.

His orders for drugs and services must be for a specific period, not exceeding 30 days. Telephone orders can only be accepted by licensed nurses and must be countersigned within 48 hours. The medication orders must be reviewed monthly for each patient by the doctor and charge nurse.

The charge nurse and other personnel involved in the patient's care should assist the doctor in planning the patient's total program of care.

Who determines the patient care policies for an ECF?

Each facility must have a committee to develop these policies. The committee must include at least one physician, one nurse, and someone who is neither an employee nor owner of the ECF, and it should consult with the people actually responsible for patient care. By the way, this same committee could serve more than one ECF in developing its policy.

While Medicare has set minimum policy standards, the committee can develop policies over and above these minimums. Since the committee would be organized on a local basis, the standards and practices within the community would be reflected in its decisions.

If a community has no ECF, can a patient remain in the hospital and receive ECF benefits after receiving hospital benefits?

NO. Medicare will not pay for ECF benefits in a hospital if the hospital has no "distinct part" meeting the requirements of an ECF facility.

Is a Utilization Review Committee required in an ECF?

Yes—it is a statutory requirement.

Since the ECF is designed to provide high quality patient care—in contrast to the custodial care which many nursing homes now provide—the Utilization Review Committee (URC) is necessary to insure optimum and appropriate use of ECF's and study patterns of patient care.

The Utilization Review Committee would function like a hospital URC—it could serve as an educational mechanism and study problems such as the over-use and mis-use of therapy and drugs, the promptness with which a doctor's orders are carried out, and the implementation of restorative and other therapeutic services. There are many areas it could explore.

Is the Utilization Review Committee required to review all Medicare cases?

No, only those cases which remain in the

ECF beyond a predetermined length of time. This period could vary with the conditions. Since the patient has remained longer than expected, his stay would be called "extended duration," and reviewed by the Committee on that basis.

Will further certification by the physician be necessary if the patient's stay is prolonged?

Yes. As for the extended hospital stays, recertification by the physician—and approved by the URC—is required to qualify a patient to continue receiving benefits.

Dr. Ford, what is ISMS policy regarding participation on Utilization Review Committees?

According to our Board of Trustees, physicians should participate in utilization review programs. Since this review is a medical function, it should be performed by physicians whether in the hospital or the ECF.

Since ECF's will not always have a large enough staff to perform the utilization review function, the Board suggests that county medical societies consider providing this service for all ECF's in the community.

(Should a county medical society desire a program on the subject of Extended Care Facilities, the Illinois State Medical Society—through its Committee on Aging—would be pleased to supply a 15-minute color slide presentation. For further information, write: Committee on Aging, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.)

* * *

Physician and medical assistant demand for copies of the AMA's version of "Winning Ways With Patients" has been so heavy that the initial printing run of 20,000 copies was exhausted within six weeks. Copies of the attractively illustrated, 20-page pamphlet, a public relations guide to medical assistants, are offered without charge. If you have not yet obtained copies for your medical assistants and yourself, just write the program Services Department, American Medical Association, 535 N. Dearborn St., Chicago 60610.



IMJ

**SURGICAL
GRAND
ROUNDS**

Case Presentation:

Pseudocyst of Pancreas

Northwestern University Medical Center

Surgical Grand Rounds are held weekly at 8 a.m., alternating between The Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of Surgical Grand Rounds held at Passavant Memorial Hospital on May 14, 1966.

Dr. Gerald Ujiki: The patient, a 56-year-old white male, entered the Veterans Administration Research Hospital April 6 of last year, with the chief complaints of abdominal pain of six months' duration and jaundice of five days' duration. The patient had been in good health until October, 1965, when he noted the onset of malaise and intermittent dull, non-radiating abdominal pain, not related to food nor to the time of day and activity. Nausea, vomiting and diarrhea were absent.

He was admitted to another hospital twice because of continued abdominal pain and in December, 1965, was told that he was "yellow." A definite diagnosis was not made. Gallbladder x-rays and an upper GI series were normal except for calcification in the area of the head of the pancreas.

In February of 1966 the patient was admitted to the Veterans Hospital for the first time with the chief complaint of continued abdominal pain and a 45-pound weight loss since October of 1965. Investigation revealed that the secretin test and the triolien fat absorption studies were abnormal and compatible with chronic pancreatitis. He was found to have diabetes mellitus and a left foot drop, thought to be secondary to diabetic neuropathy.

The liver tests were normal except for the serum alkaline phosphatase level which was elevated (32 King-Armstrong units). Serum amylase was normal. He was discharged to take a diabetic diet and Orinase.

In April he was admitted for the second time with abdominal pain and jaundice of five days' duration. He had noted light colored stools and puritus for five days. He gave a history of hepatitis in 1942. His alcoholic intake was described as "8 to 10 shots" of whiskey per day, sometimes more, for many years. Physical examination revealed a well developed, cachectic icteric white male, not in acute distress. His abdomen was scaphoid, soft, without masses, and the liver was palpated three fingers below the costal margin. A left foot drop was noted.

Laboratory: alkaline phosphatase—47 KA units; bilirubin—7 mgm % with direct fraction 4.4. The transaminase (SGOT) and serum amylase were normal. X-ray studies revealed calcification in the head of the pancreas (Figure 1). Studies of the upper gastrointestinal tract demonstrated that the stomach was unremarkable and that the duodenal loop was not distorted. An attempt at intravenous cholangiography was unsuccessful.



Fig. 1. Plain film of abdomen shows calcific deposits in the head of the pancreas which are found frequently in the presence of chronic recurrent pancreatitis.

On April 26, with a diagnosis of chronic recurrent pancreatitis, the patient was taken to the operating room and a moderate-sized cyst, about 6 cm. in diameter was found in the area of the head of the pancreas. Com-

mon duct exploration, cholecystectomy, cystojejunostomy and Roux-en-Y were performed. An operative cholangiogram demonstrated dilatation of the biliary tree.

The patient had an uneventful postoperative course. After operation, the serum alkaline phosphatase and bilirubin levels decreased. A T-tube cholangiogram on the 14th postoperative day, showed decrease in the size of the biliary ducts with passage of dye into the duodenum (Figure 2).



Fig. 2. T-tube cholangiogram was obtained in the postoperative period and demonstrates residual distortion of the distal common duct. The contrast agent enters the duodenum readily.

Dr. John Beal: This illustrates well the problem of jaundice in a patient with pancreatitis. This patient presents most of the problems of the development of a pseudocyst following recurrent pancreatitis. Pancreatic pseudocyst may follow acute pancreatitis, trauma, postoperative pancreatitis, or even pancreatitis associated with gallstones. The present patient has a chronic alcoholic history and his pancreatitis is associated with alcoholism. It may be noted that he had several episodes of pain before jaundice appeared.

Palpable abdominal masses are found in about half the patients who have pancreatic pseudocysts; however, this patient did not

have a mass to aid in the diagnosis. Radiologic evidence of duodenal or gastric displacement were absent and laboratory tests did not aid in the preoperative detection of the pseudocyst. Occasionally a patient who has an acute episode of pancreatitis will have a persistently elevated serum amylase and continued abdominal pain which should suggest the possible development of a pseudocyst. In this instance serum amylase levels remained unchanged and the diagnosis was established by operation.

The surgical treatment of pancreatic pseudocysts must vary according to size, location and status of the cyst wall. Usually the most satisfactory method was that employed in this case. A large cyst in the head of the pancreas, occupying most of the head of the pancreas may be drained into the duodenum if adjacent to the duodenal wall. I have been hesitant to drain pseudocysts of the pancreas into the stomach, having seen a patient who had a gastrointestinal hemorrhage originating in the cyst. I am aware that this is a relatively unusual complication and that drainage into the stomach has been employed for large cysts when they are firmly attached to the posterior wall of the stomach. Roux-en-Y drainage worked well in this patient where other methods including excision of the cyst did not seem feasible. External drainage is least satisfactory. *Dr. Sherrick*, can you report on the pathologic findings?

Dr. Joseph Sherrick: The Pathology Department received a biopsy of the cyst wall, which was composed of dense fibrous connective tissue and which was infiltrated with lymphocytes. The cyst was lined by flattened cells. Fat necrosis was not observed nor was there evidence of tumor.

Are these findings characteristic of pseudocyst of the pancreas? In most pseudocysts, one sees fat necrosis in the wall, or perhaps even a bit of pancreas. In a cyst that has been present for a long time, these things may disappear. I think the anatomical findings are consistent with the clinical diagnosis.

The gall bladder wall was thick and fibrous, and the mucosal folds were short, thick and adherent. There was infiltration by lymphocytes. These of course, are the findings of chronic cholecystitis.

Dr. Beal: I should like to emphasize the

importance of making a biopsy of the wall of the cyst, to exclude the possibility of cystic tumor. Dr. Anderson, would you comment on the mechanism of pseudocyst formation as well as treatment.

Dr. Marion C. Anderson: From the point of view of understanding the development of pseudocysts, it is necessary to consider the normal mechanism of secretion by the pancreas. In the normal pancreatic duct there is a definite level of sphincteric resistance, which must be overcome before secretions actually pass into the duodenum. This is approximately 20-30 cm. water pressure. Pseudocysts may occur when there is disruption in the continuity of the duct system, as in trauma. Traumatic disruption usually occurs in a normal duct so that leakage of secretions develops at levels of pressure lower than is normally necessary to overcome sphincteric resistance. The secretions that leak outside of the duct elicit a marked local inflammatory response in the pancreas. A cyst is formed when these secretions are walled off. How large the cyst becomes depends on the pressure differential between the duct and the pressure in the cyst. Probably many cysts of traumatic origin disappear spontaneously. The cyst wall may become sufficiently thick and firm so that the pressure within the cyst is higher than the pressure needed to overcome sphincter resistance. If the cyst communicates with the ductal system it then disappears.

Another cause of cyst formation is obstruction in the distal part of the pancreatic ductal system, and caused by acute and chronic pancreatitis and by tumors. The resistance to intraductal flow is increased by stricture formation in the proximal duct and ultimately causes hypertension to occur in the duct system. When the intraductal pressure exceeds 36 cm. (H_2O), leakage usually occurs. In acute pancreatitis, pancreatic juice may extravasate between the cell plates of the individual acinar cells and into the pancreatic parenchyma generally. This produces an intense inflammatory reaction. In other instances ductal rupture may occur in one of the small ducts and this may lead to cyst formation. As in trauma, the size of the cyst depends on the differential between the pressure in the duct and the pressure in the cyst. Therefore,

cysts which occur in chronic pancreatitis are much less likely to disappear, because the intraductal pressure remains elevated.

Treatment depends upon several factors. Maturity of the cyst wall will influence the type of treatment. A pseudocyst in the early stages of development has a thin, ill-defined wall and anastomosis is not feasible. External drainage is satisfactory for an acute cyst. The cyst ultimately disappears and a fistula may form. Whether the fistula closes spontaneously or persists depends upon the degree of duct obstruction proximal to the fistula. If the cyst is mature with a thick wall, it can be decompressed into the gastrointestinal tract. The type of procedure depends on the location of the pseudocyst. A well formed fistulous tract may be implanted into the gastrointestinal tract at a later stage after drainage of an acute cyst. A large cyst in the head of the pancreas may be opened directly into the duodenum. A cyst in the body of the pancreas may be decompressed into the stomach by cystogastrostomy. As mentioned by Dr. Beal, a pseudocyst may be connected to a segment of small intestine. All of these have the disadvantage of providing the opportunity of gastrointestinal contents entering the cyst cavity and bleeding has occurred in individuals, particularly with cystogastrostomy.

In the case of anastomosis of either duodenum or jejunum directly to the cyst, small bowel contents may enter the cyst. Succus entericus contains enterokinase which may activate the proteolytic enzymes contained in the cyst. Therefore, it would appear that the best treatment is decompression of the cyst by a defunctionalized loop of small bowel, Roux-en-Y, as in this particular case.

Some cysts can be resected, when they arise in the tail of the pancreas. If resection can be accomplished, the open end of the proximal pancreas should be decompressed into the gastrointestinal tract. If you tie this off, and I know that some people do, you are setting up a situation which reproduces precisely the mechanism that originated the cyst in the first place. You have re-established ductal hypertension and if drainage is not provided into the intestinal tract, the persisting hypertension will cause pancreatitis, another pseudocyst or leakage into the peritoneal cavity.

Migratory Thrombophlebitis

Heparin Sodium vs. Warfarin Sodium Therapy

By ARTHUR C. JOHNSON, M.D.
AND E. STEPHEN KURTIDES, M.D./EVANSTON

This case report is presented by the Department of Medicine, Evanston Hospital, and Northwestern University Medical School. Dr. Johnson is a resident in internal medicine and Dr. Kurtides is associate attending physician at the hospital. Dr. Kurtides is also an associate in medicine at Northwestern Medical School.

CASE REPORT

Migratory thrombophlebitis presents a diagnostic and therapeutic challenge to the clinician.¹

The purpose of this paper is to report such a case and demonstrate the unique superiority and lifesaving properties of long term heparin therapy.

Case Report:

A 55-year-old white male was re-admitted to the Evanston Hospital in October, 1964, with history of migratory thrombophlebitis of six months' duration.

In April, 1964, he was first admitted to our institution for thrombophlebitis in the left leg for which he was treated with a three-day course of sodium heparin subcutaneously. This was followed by sodium warfarin (Coumadin) orally (5 to 10 mg. daily) and he was discharged on this regimen.

In June, 1964, despite adequate anticoagulant therapy (one stage prothrombin time range: 25 to 35 seconds), he developed thrombophlebitis in the left thigh associated with a single episode of pulmonary embolism. He was again treated as during the first admission and underwent ligation of the left greater saphenous vein. The patient recovered without incident and was again discharged on sodium warfarin maintenance therapy.

In July, 1964, while vacationing in New York City, he experienced severe chest pain and two episodes of hemoptysis. He was admitted to one of the major university hospitals there, where after a negative search for a neoplasm including a negative exploratory laparotomy, ligation of the inferior vena cava was performed. He made an uneventful recovery and was discharged on sodium warfarin maintenance therapy.

Occlusion of Veins

In August, 1964, acute swelling of the right side of the face and neck occurred. The pertinent physical findings at that time included edema of the face, neck, and both upper extremities, with palpable superficial venous thromboses in most of the veins of the upper extremities. The liver was enlarged to about 3 cm. below the right costal margin. Both lower extremities were edematous and hyperemic. Dermato-phytosis was noted in all the toes. An emergency phlebogram revealed occlusion at the junction of the right jugular and subclavian veins.

Treatment was initiated via a continuous intravenous heparin drip aimed at a $2\frac{1}{2}$ to 3 fold prolongation of the Lee-White blood clotting time.

Subsequently, extensive studies were undertaken in an effort to uncover an occult neoplasm. These included radiographic studies of the chest, upper gastrointestinal tract, small and large bowel series, gall-bladder series, intravenous pyelogram, and a skeletal survey. A proctosigmoidoscopy to 24 cm. was negative and many laboratory studies were undertaken. Some of these were abnormal but difficult to interpret.

The latter were a mild decrease in serum albumin to 2.96 gms. per cent, a 3 plus Cephalin-Cholesterol Flocculation, and a reactive Latex Fixation test for Rheumatoid Arthritis in the absence of arthritis.

Intravenous Heparin Therapy

Intravenous heparin therapy was continued uninterruptedly for four weeks at an average daily dosage of about 400 mg. of heparin sodium. During this period the patient experienced a single episode of chest pain with light hemoptysis, but the edema subsided in all areas and the palpable thrombi literally melted away. The patient became asymptomatic at the end of this period and the intravenous heparin therapy was replaced by deep subcutaneous heparin injections ("Lipo-Hepin") of 150 to 200 mg. every 12 hours. On this regimen the Lee-White clotting time at 11 hours post-injection was found to range between 25 and 30 minutes. He was discharged in good condition six weeks after the initiation of heparin therapy and continued on the same heparin program at home with clotting times determined every three days.

The patient remained asymptomatic and returned to work until late January, 1965. At that time he developed progressive dyspnea and right sided chest pain for which he was re-admitted to our hospital. A bloody right sided effusion was discovered and shown to contain adenocarcinoma cells. He remained on the heparin maintenance therapy and died four weeks later at home without recurrence of thrombophlebitis.

Widespread Metastases Noted

Autopsy demonstrated poorly differentiated adenocarcinoma with a possible primary site in the right lung. Widespread metastases were noted in the thyroid, both lungs, hilar mediastinal nodes, the pericardium, pleura, several small metastases were found in the liver mainly in the subcapsular areas, pancreas, right adrenal, mesenteric nodes, pelvic peritoneum, urinary bladder, left ureter (with partial obstruction), and the lumbar bone marrow.

With the exception of a small organized thrombus in one of the terminal branches of the right lower lobe arteries no thrombi were found elsewhere at autopsy.

Discussion

Migratory thrombophlebitis may at times be the initial symptom of neoplastic disease. Such an association has been reported in bronchogenic carcinoma and carcinomas of the pancreas, stomach, prostate, and ovary among others.^{1, 2, 3}

It has been suggested that thrombus formation may be due to the release of trypsin or a similar enzyme and tissue thromboplastin in the circulating blood by the carcinoma.⁴ Another mechanism might be the activation of intrinsic thromboplastin by tumor invading the venous wall.^{5, 6} More recently it has been proposed that hypercoagulability may be originating from the increase in circulating platelets known to occur in patients with neoplastic diseases.¹

One of the major problems in the treatment of thromboembolic disease in general lies in the failure of the currently used tests to reflect the true state of anticoagulation. It has further been shown that coumarin compounds are generally ineffective in preventing experimentally induced thrombosis in animals.^{7, 8, 9} By contrast heparin has been repeatedly found to be effective under similar conditions.⁷⁻¹¹

Effect of Coumarin Drug

Another aspect of anticoagulant therapy requiring further emphasis is the lack of correlation between the early "satisfactory" prolongation of the "one-stage prothrombin time" during coumarin drug therapy and the actual occurrence of adequate anticoagulation. The latter is not established until about the fifth to the seventh day of treatment.¹² Consequently the coumarin drugs should not be relied upon in initiating anticoagulant therapy in thromboembolic disease. Heparin on the other hand is the drug of choice in establishing emergency anticoagulant therapy since it blocks the action of thrombin and interferes with the activation of thromboplastin.¹³

The usefulness of heparin in the treatment of thrombophlebitis has been amply demonstrated.^{15, 16} In a retrospective study it has been noted that heparin failed only once out of 195 cases of thrombophlebitis treated. By contrast coumarin failed in 14 of 26 cases of thrombophlebitis. It is noteworthy that these 14 cases responded well to a subsequent course of heparin therapy.¹⁵

Incidence of Osteoporosis

While the most physiologic route of heparin administration is the continuous intravenous drip as employed in our case during the first four weeks of treatment, the patient findings confirm that the subcutaneous route is equally effective especially for long term maintenance treatment.^{15, 17, 18}

Recently attention has been drawn to the increased incidence of osteoporosis following long term heparin therapy.¹⁹ However, one may well accept this as a calculated risk in the presence of life threatening thromboembolic disease.

The present case offers clear documentation of the difference between the anticoagulant effects of the coumarin compounds and the antithrombotic effects of heparin. It has been shown repeatedly that a very adequate prolongation of the one-stage prothrombin time failed to protect our patient from re-

current thromboembolic disease over a five-month period of constant coumarin therapy. By contrast these manifestations fully subsided upon institution of heparin therapy and were accompanied by complete resolution of all pre-existing thrombi, while no further recurrence of thrombophlebitis was noted during the second five month period of his illness, that of heparin rather than coumadin therapy.

Summary

A case of migratory thrombophlebitis associated with a poorly differentiated *adenocarcinoma* of the lung has been described. "Adequate" coumarin therapy over a five-month period failed to prevent recurrent thromboembolic disease. By contrast continuous heparin therapy fully controlled the hypercoagulable state and was followed by complete resolution of all pre-existing thrombi.

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Sulfacetamide Sodium in Inflammatory Ophthalmic Disorders

Evaluation in the Treatment of 51 Patients

By JOHN W. VERTUNO, M.D./CHICAGO

In recent years many different antibiotics—penicillins, tetracyclines, etc.—have appeared with a variety of claims and counter-claims as to their effectiveness, making a definite decision somewhat confusing to the physician. The question of bacterial resistance is still largely unanswered; no proved specific agent effective against ordinary viruses has been encountered. The last page on these antimicrobial agents has not been written.

Nevertheless, glowing reports on new antibiotics have the tendency to influence the practicing physician in his therapeutic recommendations. The temptation to substitute the "new" for the "old" is very strong. In many instances extensive controlled critical evaluations on the real efficacy and genuine safety of a newer drug has not become public until after the enthusiastic practitioner realizes that the benefit sought was not forthcoming and unfavorable and unnecessary side effects spelled only added discomfort.

Results Well Documented

The literature is replete with well documented reports of clinical results with some older drugs; and because these drugs have been on the market a longer time does not justify their being relegated to the shelf of disuse. These earlier drugs, backed by a larger clinical experience, can "stand on their record." Saslaw¹ warns against "juggling and changing of antimicrobial agents" and suggests that if the infection

under consideration is due to organisms sensitive to older preparations, these agents should not be traded in for newer models.

The sulfonamides belong to the category of "older" drugs. These antibiotics still constitute an excellent first line of defense against certain infections, provided the physician has ascertained the etiology of an infection and is cognizant of the potentialities, limitations, and toxicities of the sulfonamide involved.

Sulfacetamide Still Needed

Sulfacetamide sodium* represents one of the sulfonamides which has been used to great advantage for many years and which is still needed. This highly soluble drug exerts a powerful bacteriostatic effect against a wide range of gram-positive and gram-negative micro-organisms. The ophthalmic solution penetrates ocular tissues and is virtually free from local irritation. Wide usage for many years has established its remarkable freedom from sensitizing action.

Sulfacetamide sodium has been proved effective prophylactically following corneal abrasions, lacerations, or burns; after removal of foreign bodies; and in the treatment of the more common infections of the eye, such as acute and chronic conjunctivitis, corneal ulcer, dacryocystitis, and styes. It exerts a wide margin of safety against

*Sodium Sulamyd®, Schering Corporation, Union/Bloomfield, N. J.

corneal damage. Superficial keratomycosis responds favorably to sulfacetamide sodium with little or no visual loss.

Bringing the effectiveness of this antibiotic back into professional focus was one of the incentives for this investigation.

Material

The material presented herein covers the clinical experience of over five months with 51 patients seen either in general practice or at the clinic who were treated topically with the 10% ophthalmic solution of sulfacetamide sodium. One or two drops of the solution were instilled in the eye socket every two or three hours depending upon the pathologic condition.

The patients ranged in age from two to 83 years. The general presenting symptoms were congestion, inflammation, discharge, tearing, and pain. These complaints were bilateral in 20 of the subjects studied. Several patients suffered with chalazia; eye injuries; or foreign bodies, conjunctival or corneal, either superficial or embedded. In the majority of patients, acute or chronic conjunctivitis existed. The shortest period of treatment required one week, the longest three months. (See Table on pages 60 and 61.)

Results

General: In an overall breakdown of response to therapy, 36 patients or 71% showed excellent or good results; 15 or 29% showed improvement or alleviation of symptoms. (See Table) In only one patient (Case 13) was the result considered "fair." However, the pathologic condition in this instance had been in progress for seven years, and a degenerating process may have been a factor in the outcome of treatment.

Conjunctivitis: *Acute* or *chronic* conjunctivitis was encountered in 35 patients. Those conditions considered acute usually responded very readily to treatment. However, when conjunctival congestion had existed for a long period of time, the response to treatment was slower; chronicity constituted a deterring element in the rapidity of favorable outcome (Cases 5, 8, 21, 31, 46). When the ducts were found permeable, probing and flushing were carried out followed by the prophylactic installation of sulfacetamide sodium. In each instance no infection resulted, and the conjunctival

symptoms either abated completely or were considerably lessened. One of the chronic conditions (Case 5), aggravated by dacryostenosis, responded well to therapy although treatment had to be extended over a period of three months. Additional treatment of the structure could correct the disturbance completely.

In addition to chronic conjunctivitis, one patient (Case 20) had bilateral pterygium, the symptoms of which the patient dates to the time of nasal surgery carried out in Japan approximately ten years previously. In this instance the nasal passages were treated concomitantly with the eye symptoms. The latter showed improvement, but the results can be considered only temporary until the nasal disorder has been fully corrected.

Injury and/or Foreign Body: The history of injury to the eye or the presence of a foreign body was elicited from nine patients. In each instance after foreign body removal, sulfacetamide sodium instillation prevented infection. This same satisfactory outcome followed treatment of eye injuries. Cessation of symptoms and prevention of infection followed the use of sulfacetamide sodium in each injury treated.

Chalazion: Three patients with chalazia experienced rapid relief of conjunctival congestion after removal of the sty and the topical application of sulfacetamide sodium. Infection never occurred in any case.

Miscellaneous: The patient in Case 11, whose only symptom was tearing for six months, showed immediate response to sulfacetamide sodium. Bilateral corneal dystrophy in Case 41 and the patient's advanced age contributed to a less than favorable outcome, although some improvement was shown in local irritation with the use of sulfacetamide. In cases in which the immediate response to therapy was either good or excellent but the patient did not return for an additional check-up, we have assumed that the end result was complete healing or alleviation of symptoms.

Comments

In a general review² of the sulfonamides the *British Medical Journal* in 1964 mentioned the high solubility of sulfacetamide, one of the drug's merits, and pointed out that sulfonamides, which are bacteriostatic,

do not antagonize the action of bactericidal antibiotics and that serious side effects are rare.

Gingrich³ recommends sulfacetamide sodium for superficial keratomycosis and reports the advantage of intensive therapy with this antimicrobial agent supplemented with systemic medication in a rare case encountered in his practice. This author states that cure of superficial keratomycosis caused by *Nocardia asteroides* can be effected with sulfacetamide alone. For deep fungus keratitis he recommends the sulfacetamide-thimersol treatment.

Discussing the frequency of ocular injuries and their treatment, Vail⁴ calls attention to the fact that infection is always possible in scratches, erosions, and abrasions of the cornea. He advocates the use of sulfacetamide sodium as the most useful antibiotic in such emergencies, since very few people are sensitive to this drug; while some other agents have a tendency to cause allergic reactions, both local and general, and are known to sensitize the patient. In our own experience, sulfacetamide sodium has proved nonsensitizing.

Summary and Conclusions

- (1) A plea is made for continued analysis of the therapeutic and toxic properties of established older drugs, backed by well documented experience, in order

to prevent them from being banished to the limbo of disuse.

- (2) To keep one of these valuable drugs—sulfacetamide sodium—before the professional eye, a study was made to support previous reports and to supplement newer findings.
- (3) The review covered the pathologic conditions existing in the eyes of 51 patients treated with the 10% solution of sulfacetamide sodium.
- (4) Pertinent data regarding the patient, eye condition, treatment, and results are carefully tabulated.
- (5) Response to sulfacetamide sodium was quick and effective.
- (6) Sensitivity to the medication was negligible, and in combination with steroid medication, was ideal therapy for those cases complicated by allergy.
- (7) It is our belief that sulfacetamide sodium is preferable to other ophthalmic solutions from the standpoint of safety, rapid relief, and nonsensitizing feature.

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(See Table on pages 60 and 61)

* * *

The AMA has endorsed a seminar service on immunization for state and county medical societies. The seminar service was designed by the Communicable Disease Center in Atlanta, Georgia, in cooperation with the AMA's Council on Environmental and Public Health. The seminars contain a wide choice of presentations, authoritative speakers and the latest information on all aspects of immunization. Medical society seminars on communicable disease can be arranged by contacting the Center, Atlanta, Ga. 30333, which will send a representative. There is no charge for this seminar service, its speakers or its literature.

SULFACETAMIDE SODIUM IN INFLAMMATORY OPHTHALMIC DISORDERS

Results in 51 Patients

Patient	Age - Sex	Eyes Involved	Symptoms	Diagnosis	Period of Treatment	Result	Remarks
(1)	53,M	Left	Congested conjunctiva;	AC*	18 days	Improved	Responded to treatment; some itching for 2 days
(2)	70,M	Bilateral	Congested conjunctiva; swelling; pus discharge	AC	1 1/2 mo.	Improved	Some congestion in lower lid persisted
(3)	63,M	Bilateral	Congested conjunctiva; pus discharge; sensation of F.B.*	CC**	1 mo.	Excellent	Effective response
(4)	38,F	Left	Swollen lid; soreness; inflammation	Chalazion	1 wk.	Good	Symptoms reduced
(5)	55,F	Bilateral	Tearing; chronic sinusitis	CC dacryostenosis	3 mo.	Good	Condition improved; ducts permeable; probing suggested
(6)	82,M	Bilateral	Congested conjunctiva; tearing	CC	2 mo.	Improved	Ducts probed and flushed; additional lacrimal system treatment necessary
(7)	42,F	Left	Congested conjunctiva; sensation of F.B.; small corneal opacity	F.B. (not seen)	2 wk.	Excellent	Cornea clear; complete healing
(8)	35,F	Bilateral	Congested conjunctiva over long period; mucous discharge	CC	2 mo.	Slow response	This condition difficult to cure
(9)	19,F	Left	Congested conjunctiva; some discharge	AC	2 wk.	Good	Satisfactory response
(10)	62,M	Bilateral	Congested conjunctiva; inflammation; discharge	AC	3 wk.	Excellent	Healing of inflammation and infection
(11)	56,M	Left	Tearing for 6 months	X	1 mo.	Excellent	Immediate response
(12)	30,F	Left	Stye upper lid	Chalazion	2 1/2 wk.	Excellent	Rapid response
(13)	62,F	Bilateral	Discharge; burning; cloudy vision in rt. eye for 7 yrs.	CC	7 wk.	Fair	Degenerating process may be factor
(14)	56,M	Right	Congestion; discharge; inflammation	AC	3 wk.	Good	Some congestion and tearing present; ducts show no obstruction
(15)	33,M	Bilateral	Congested conjunctiva; sensation of F.B.	AC	10 days	Excellent	Immediate response
(16)	81,M	Bilateral	Constant tearing	Obstr. of ducts	1 wk.	Improved	Surgery of tear ducts suggested
(17)	59,M	Bilateral	Congested conjunctiva; blurred vision; pale disc	CC	2 wk.	Improved	Conjunctiva more normal
(18)	42,M	Right	Conjunctivitis; soreness	CC chalazion	2 wk.	Good	Conjunctivitis healed
(19)	47,M	Right	Swelling; pus discharge; tearing	CC	2 wk.	Good	Effective results
(20)	31,M	Bilateral	Inflammation; discharge	CC pterygium	2 wk.	Good	Nasal symptoms to be corrected
(21)	74,M	Right	Tearing; discharge; blocked ducts	CC	3 mo.	Improved	Chronicity prevented complete cure
(22)	X	Left	Congested conjunctiva; discharge; keratitis	AC	2 wk.	Excellent	Immediate response; cornea clearer
(23)	29,F	Right	Eye struck; corneal staining	Corneal abrasion	9 days	Excellent	Completely healed
(24)	14,M	Bilateral	Moderate congestion; discharge; soreness	Mild conjunctivitis	2 wk.	Excellent	Treatment effective
(25)	67,F	Bilateral	Congested conjunctiva; mucous discharge	AC	2 wk.	Excellent	Rapid response

SULFACETAMIDE SODIUM IN INFLAMMATORY OPHTHALMIC DISORDERS

(Cont.)

Patient	Age - Sex	Eyes Involved	Symptoms	Diagnosis	Period of Treatment	Result	Remarks
(26)	62,F	Bilateral	Slight discharge; discomfort	AC	1 wk.	Excellent	Patient reported great improvement
(27)	X ,M	Left	Sensation of foreign body; tearing	Rust ring on cornea	10 days	Good	Immediate response; infection prevented
(28)	40,F	Left	Congested conjunctiva; discharge	AC	10 days	Good	Rapid response
(29)	39,M	Left	Congested conjunctiva; mucopurulent discharge	AC	X	Good	No follow-up
(30)	56,M	Left	Tearing; burning sensation; Bell's palsy	CC	1 wk.	Improved	Infection prevented
(31)	48,M	Right	Congested conjunctiva; small cyst; tearing	CC	3 wk.	Improved	Chronicity and time element influencing factor
(32)	50,M	Left	Tearing; pain	F.B.	X	Good	No infection
(33)	79,M	Bilateral	Corneal scarring; tearing	CC	1 mo.	Good	Treatment effective in tear duct obstruction
(34)	50,F	Right	Sensation of F.B.; tearing	F.B.	1 wk.	Excellent	No infection
(35)	59,M	Left	Injury; corneal abrasion	F.B.	10 days	Excellent	No infection
(36)	45,F	Bilateral	Congested conjunctiva; itching; burning	Moderate conjunctivitis	2 wk.	Improved	Steroid added to therapy
(37)	58,F	Left	Swelling; discharge; inflammation	AC	9 days	Improved	Antibiotic added to therapy
(38)	27,M	Left	Corneal staining; pain; inflammation	Injury from nail	12 days	Excellent	Symptoms disappeared; no corneal staining
(39)	2,M	Right	Tearing; discharge	CC	X	Good	No follow-up
(40)	28,M	Bilateral	Mild congestion; discharge	CC	1 wk.	Good	No follow-up
(41)	83,M	Bilateral	Irritation; corneal opacities	Corneal dystrophy	1 wk.	Improved	Symptoms alleviated
(42)	68,M	Left	Sensation of F.B.; congestion; tearing	F.B.	1 wk.	Excellent	Immediate response
(43)	54,F	Right	Congested conjunctiva; tearing; burning	Injury	1 wk.	Good	Symptoms subsided
(44)	24,F	Right	Congestion; irritation; discharge	AC	2 wk.	Good	No discharge or inflammation
(45)	4½,M	Right	Tearing; discharge	Duct obstruction	1 wk.	Good	Probing of tear duct advised
(46)	27,M	Bilateral	Congested conjunctiva; discharge	CC	1 mo.	Improved	Chronicity a factor
(47)	66,M	Bilateral	Congested conjunctiva; burning	CC	X	Good	No follow-up
(48)	64,F	Left	Tearing	Duct obstruction	1 wk.	Good	Tear ducts probed
(49)	51,F	Left	Slight conjunctival congestion	CC	2 wk.	Good	Medication efficacious
(50)	40,F	Left	Congested conjunctiva; mucopurulent discharge	AC	2 wk.	Excellent	Immediate response
(51)	46,M	Right	Congested conjunctiva; corneal staining; tearing	Keratoconjunctivitis	1 wk.	Good	Infection prevented

*AC: acute conjunctivitis

**CC: chronic conjunctivitis

+F.B.: foreign body

for January, 1967



THE VIEW BOX



Fig. 1

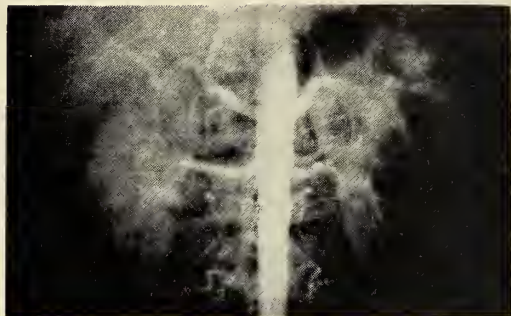


Fig. 2



Fig. 3



Fig. 4

LEON LOVE, M.D.
DIRECTOR, DIAGNOSTIC RADIOLOGY
COOK COUNTY HOSPITAL

This 33 W/M entered Cook County Hospital following blunt abdominal trauma resulting from a head on collision. He complained of generalized soreness in the abdomen and flanks.

Physical examination revealed a well developed patient in no acute distress with diffuse abdominal tenderness. However, no tenderness was elicited in the flanks. The patient was observed for 12 hours and, because of a falling hematocrit and microscopic hematuria, he was sent to X-ray for an I.V.P. which was immediately followed by an abdominal aortogram. Fig. 1, 2, 3, 4.

What's your diagnosis?

(Answer on page 73)

Conductive Hearing Loss in Cleft Palate Patients

By SALLY J. PETERSON, M.A./CHICAGO

It has become axiomatic that the incidence of conductive hearing loss in cleft palate patients is higher than that found in the general population^{3, 4, 9, 17, 20, 21}. Critical analysis of the research which has been reported on this topic revealed several areas in which there had been a lack of agreement among authors. The principal points of contention related to the following:

- 1) The percentage of cleft palate patients that may be expected to have a conductive hearing loss. The disagreement on this question appeared to stem primarily from two factors:

- a) differences in the working definitions of "hearing loss" used by various investigators, and
- b) differences in the types of cleft palate populations tested.

- 2) The incidence of conductive loss as a function of the age of the patient.

- 3) The relationship between conductive loss and the type of cleft present.

- 4) The physiological mechanisms which are responsible for middle ear infections and consequent conductive hearing impairment in these patients.

- 5) The incidence of conductive loss as a function of the physical management of the cleft.

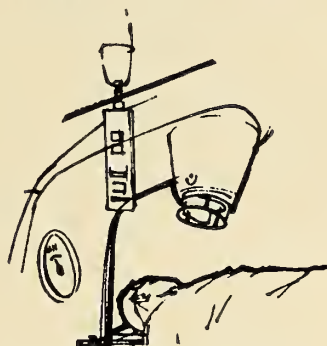
The lack of agreement on these questions recorded in the literature casts doubt on some of the generally accepted statements which have been made about hearing loss in cleft palate patients. This doubt is re-

inforced by the almost universal lack of well documented clinical and experimental papers. It is the purpose of this review to summarize the major points of disagreement and to underscore the problems involved in conducting research in this area.

What is a "Hearing Loss"?

The problem of a consistent definition of "hearing loss" is not unique to those investigators working with cleft palate patients. In the field of audiology, no uniform set of criteria has been agreed upon for

Medical Progress



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determining whether or not a loss is present. Audiologists differ widely on both the frequency range and the threshold levels which should be specified in defining a hearing loss. Spiestersbach, Lierle, Moll, and Prather²⁴ have demonstrated that for the same population the incidence of hearing loss could range from 3% to 74% merely by using various criteria to define "hearing loss." The estimates of the percentage of cleft palate patients who may be expected to

have a conductive hearing loss range from 39%²³ to 61%¹². Hayes¹⁰ stated that it must first be decided whether medically significant or educationally significant hearing losses are being identified. He proposed two definitions: that a medically significant loss be one which shows a deviation of 15 dB, re ASA 1951 audiometric 0, at two frequencies between 250 and 8000 Hz and that an educationally significant hearing loss be one which shows an average loss of 20 dB in the speech frequencies of 500 to 2000 Hz¹⁰.

The difficulty in evaluating the figures given for incidence of hearing loss in the cleft palate population comes not only from the lack of agreement on what constituted a loss but also from the failure to designate the criteria employed. Thus, Berry and Eisensohn¹ stated that less than 60% of the cleft palate children in the Rockford College Center were found to have "hearing handicaps." However, the term "hearing handicaps" was not defined. Drettner³ stated that 49% of the 63 patients he tested had auditory impairment of 15 dB or more throughout the speech range, but he failed to clarify whether this represented bilateral hearing loss or the hearing in the worse ear. Lindsay et al¹⁴ reported that 58% of his patients were found to have a loss of 20 dB or more. Halfond and Ballenger⁹ tested 69 cleft lip and cleft palate persons audiologically and otorhinologically. They found that 54% had losses of 20 dB or greater at two or more frequencies in both ears. Miller¹⁹ tested 35 patients, aged three to 23 years, throughout the frequency range from 125 to 12,000 Hz. He found 19 of these patients to have a loss of 30 dB or more for any one of these frequencies, and concluded that the more frequent type of conductive loss in the cleft palate population was in the high frequencies¹⁹. Skolnik²³ conducted a study on middle ear pathology and hearing loss in various subgroups of a cleft palate population of 401. The incidence of hearing loss was reported as 39.4%, but the criteria for determining the presence of a loss were not specified. In a study reported by Holmes and Reed¹², 16 out of 24 patients had a loss greater than 10 dB in one or both ears, while 12 of these 16 had a loss greater than 20 dB. Means and Irvin¹⁸ found losses of either 25 dB at one or more fre-

quencies from 250 to 2000 Hz or 30 dB at 4000 or 8000 Hz in 52.7% of 225 children aged three to 16. Linthicum et al¹⁵ reported hearing losses of 15 to 30 dB in 40% of a group of 100 children with cleft palate.

What is the Incidence of Conductive Loss as a Function of Age?

It must be remembered that at least part of this disagreement in the incidence of hearing loss is due to the different subgroups which have been tested. One variable which makes it impossible to treat the entire cleft palate population as one group is, of course, the factor of age. In the previously mentioned study by Skolnik²³, it was found that for cleft palate children there is a gradual increase in middle ear pathology with age up through age 13. Glover⁵ found that cleft palate children between the ages of two to five years have repeated middle ear infections whether or not the palate has been repaired. These results would appear to support Skolnik's data²³. Spriestersbach et al.²⁴ also investigated hearing in cleft palate children as a function of age. They found a smaller incidence of hearing loss and a smaller magnitude of threshold deviations in children over six years of age than in those under six. In contrast to the results of these studies conducted on children are those obtained by Goetzinger et al.⁶ when they tested 42 cleft palate adults ranging in age from 16 to 75 years. These investigators found that, as a group, their subjects possessed a hearing level which was within normal limits. Furthermore, the auditory discrimination scores for these subjects were also within the limits of normal hearing⁶.

What is the Incidence of Conductive Loss as a Function of the Type of Cleft?

There have been several studies which have attempted to determine the relationship between hearing loss in the cleft palate population and the type of cleft present. Spriestersbach et al.²⁴ found that hearing loss tended to occur more frequently in children with isolated clefts of the palate than in children with clefts of both the lip and palate. However, the difference between the two groups was not statistically

significant. In a study conducted by Masters, Bingham, and Robinson¹⁷ on 172 children with cleft palate, the highest incidence of hearing loss occurred in wide palatal clefts involving both the soft and hard palate. Skolnik's data²³ demonstrated the greatest occurrence of ear pathology to be in clefts of the soft palate only, followed by submucous clefts and unilateral clefts of the lip and palate. However, no statistical analyses of these data were carried out to determine the significance of his measurements. In the same group of subjects, no relationship could be found between the incidence of ear pathology and the width of the cleft²³. Drettner³ found the greater incidence of aural pathology to occur in cases of cleft lip and palate as opposed to those of cleft palate only. This is in direct contrast to the findings of Spriestersbach et al.²⁴. Holmes and Reed¹² could establish no relationship between hearing loss and the severity of the primary deformity in their subjects.

What are the Physiological Mechanisms of Conductive Hearing Loss in Cleft Palate Patients?

The observations and conclusions which have been made regarding the physiological mechanisms responsible for conductive hearing loss in cleft palate patients have been proposed both on theoretical grounds, with either supportive or circumstantial evidence, and on the basis of experimental data. On the basis of circumstantial evidence, Miller²⁰ described the following three factors which he feels bear a casual relationship to conductive impairments in these patients:

- 1) Lymphoid hyperplasia in the nasopharynx. (The implication seemed to be that hyperplasia was secondary to the chronic upper respiratory infections common to the child with a cleft rather than assuming a hyperplasia that was intrinsic to the syndrome.)
- 2) The abnormal condition to which the eustachian tube is exposed in cleft palate cases.
- 3) Disturbances of eustachian tube function secondary to mutilating surgery. (Specific description of the kind and nature of such surgery was not given.)

The lymphoid tissue surrounding the eu-

stachian tube is often infected, producing otitis media and a consequent hearing loss¹.

This lymphoid tissue prevents proper aeration through the eustachian tube, causing a disparity in pressures between the external and middle ears¹. In addition to the possibility of infection of the lymphoid tissue, the cleft in the palate itself and the incomplete closure of the naso-pharyngeal port expose the eustachian tube and thus

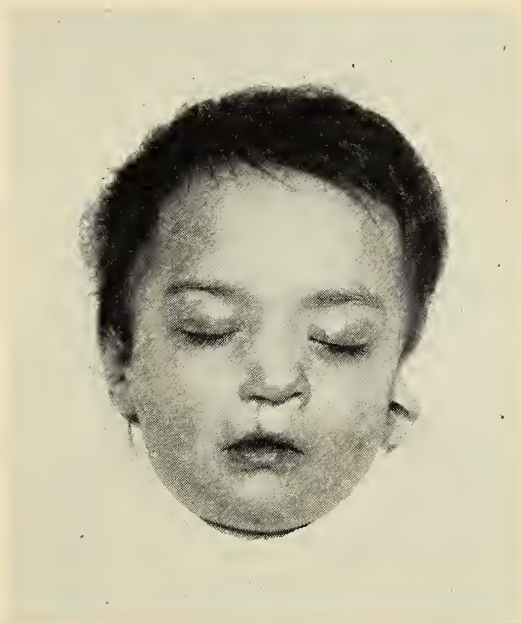


Fig. 1. "Microtia with contralateral unilateral cleft lip and palate." (Courtesy, Cleft Palate Clinic, University of Illinois)

the middle ear to infectious organisms.^{2, 13, 17, 19.}

Holborow¹¹ conducted a study to determine the importance of the tensor palatini muscle in normal function of the eustachian tube. He found that when this muscle was severed in dogs, it was impossible to normalize the middle ear pressures from artificially induced positive and negative pressures. On the basis of these experiments, he suggested that hearing impairment in cleft palate children was related to malfunction of the tensor palatini muscle as a result of (1) poor muscle development, (2) absence of firm anchorage for the muscle, or (3) damage to the muscle during surgery including alteration of the angle of pull by fracture of the hamulus, nerve injury, and/or scarring and fibrosis around the

muscle. Linthicum¹⁵ also discussed middle ear changes in the cleft palate child as related to dysfunction of the tensor palatini muscle and the resultant problem in air pressures. In addition to these factors, he listed several other possible causes of middle ear changes, among them: 1) trauma to the exposed tubal orifice during swallowing, 2) interference with drainage of fluid collection, 3) scarring or atrophy of palate muscles, 4) embryological distortions, 5) injury during surgical repair, and 6) allergic swelling around the proximal end of the eustachian tube¹⁵.

Schultz²² produced cleft palates by surgical means in 30 rabbits for the purpose of studying the incidence and histopathologic aspects of resulting middle ear infections. He found that 82% of the 60 ears examined after clefting demonstrated histologic evidence of inflammatory reaction. Seventy-five percent displayed evidence of chronic otitis media. The primary factor responsible for the histopathology in the eustachian tube and the middle ear was ascribed to the loss of function of the levator and tensor veli palatini muscles. Another histopathologic finding in this study was the observation of one or more layers of new bone within the walls of the bullae in half of those animals allowed to live for more than 30 days with cleft palate. On the basis of these results, it was suggested that a similar process of new bone deposition might also occur in man, and that this might be the basic cause for conductive deafness in patients with cleft palates²².

What is the Incidence of Conductive Loss as a Function of Physical Management?

Evaluation of the relationship between the kind of treatment directed at the cleft and the hearing of the patient was complicated by a number of variables which were inherent in such treatment. These included the age of the patient at the time of surgery, the type of surgery, and the number of operations; whether or not the patient was fitted with a prosthesis, the age at the time of fitting, the adequacy of the prosthesis, and whether a combination of surgery and prosthesis was used. A number of investigators have attempted to deal with one or several of these factors in their studies. Age

at operation was considered as a separate parameter whereas in reality it may be merely the resultant of several variables converging to favor early surgery in one instance or causing deferral until some later age when more favorable circumstances might obtain.

The same was true in evaluating the relationship between hearing and the presence of a prosthesis: the child who had been fitted with a prosthesis was usually the child for whom palatal closure could not or did not result in adequate velopharyngeal function. In both cases, the early presenting morphology might have influenced later middle ear infections in two ways: 1) in determining the physical management of the cleft, and 2) in the effect of the pathology itself on such things as eustachian tube function.

In short, age is not a reliable parameter in terms of physical management, for such management may be dependent on anatomic and physiologic variants which in themselves might minimize the hazard to hearing. The great majority of authors dealing with the subject of hearing loss in the cleft palate population failed to consider this point.

Masters et al.¹⁷ claimed that the age of palatal repair played a significant role in producing or preventing hearing loss. They stated that if surgery was delayed beyond the age of 18 months, "the incidence of hearing loss appears to rise almost by arithmetic progression as age increases." However, the age at the time of auditory testing was not considered by these authors. Spriestersbach et al.²⁴ found that children who were between 30 and 48 months of age when their palates were surgically repaired had poorer pure tone thresholds in both ears than did children either younger (25 months or less) or older (49 months or more) at the time of repair. However, the authors stated that, in their opinion, the differences in thresholds were probably due to the age differences between the three groups of children at the time of testing²⁴. Skolnik²³ investigated middle ear pathology in two groups of school age children. One group had had surgical repair of the palate before one year of age; the other, palatal closure after two years of age. The percentage of middle ear path-



Fig. 2. "Variety of common facial clefts ranging from incomplete unilateral cleft lip to complete cleft lip, and bilateral clefts of the lip." (Courtesy, S. Pruzansky, Cleft Palate Clinic, University of Illinois)

ology was approximately the same for the two groups. Holmes and Reed¹² also found no definite relationship between hearing and the age of palatal closure, although they stated that "there does seem to be a tendency indicating that the earlier the closure the better the hearing."

Only two studies have been reported concerning the effects of different types of surgical procedures on the hearing of cleft palate patients. Graham and Lierle⁷ evaluated the effects of posterior pharyngeal flap palatoplasty on the hearing and otologic condition of 43 cleft palate patients aged seven to 26. None of the patients developed a middle ear infection following surgery except where there had been a previous infection. Nor did any subject develop a greater hearing loss following surgery⁷. In comparing two surgical techniques, Masters et al.¹⁷ found a lower incidence of hearing loss when the method of surgical repair

used was closure with lengthening of the palate than when the method was surgical closure without lengthening¹⁷.

In the same study¹⁷, Masters and his co-workers found a higher incidence of hearing loss in those patients who had been fitted with obturators than in those whose palates had been surgically repaired. These authors stated that there were two problems inherent in prosthetic rehabilitation of a cleft palate. The first is the difficulty in constructing and maintaining an obturator for a child under two years of age; the second is the fact that a prosthesis cannot restore the dynamic function of the palatal musculature. They accounted for the difference in incidence of hearing loss between the prosthetically-repaired and the surgically-repaired patients on the basis of a difference in the intactness of the anatomy of the eustachian tube and its extrinsic musculature, specifically the levator and tensor palatini.

Spriestersbach et al.²⁴ also found a difference in incidence of hearing loss, although only in the better ear, between those patients whose palates had been surgically repaired and those who had been fitted with obturators. However, they take issue with the conclusion of Masters et al.¹⁷ that this difference was due to the lack of intactness of the levator and tensor palatini. In the Spriestersbach et al. study²⁴, the degree of loss was not significantly different between the surgically-treated and the prosthetically-treated groups. Furthermore, there were no significant differences between those patients whose palates were unrepaired and those whose palates had been repaired surgically. These findings raised a question as to the importance assigned by Masters et al.¹⁷ and others^{11, 22} to the role of the levator and tensor palatini in the prevention of middle ear disease and hearing loss.

Loeb¹⁶ reported finding a positive correlation between hearing loss and the number of years that the patients had worn a prosthesis. He observed that these were patients with such poor velopharyngeal relationship that surgical closure was not feasible. He noted that a prosthesis might cause decreased eustachian tube function and therefore contribute to increased occurrence of hearing loss. Graham, Schweiger, and Olin⁸ studied the incidence of middle ear infection and hearing loss both before and after insertion of an obturator. They found no cases in which ear infections developed for the first time following the insertion of an obturator. Nor were there any cases in which the magnitude of the hearing loss became greater following obturator insertion⁸.

A few investigators have attempted to determine the relationship between hearing loss in the cleft palate patient and other physiological factors such as the presence or absence of nasal obstruction, adenoid tissue, and so on. Holmes and Reed¹² found no relationship between hearing in their subjects and the presence or absence of adenoid tissue in those patients in whom it was possible to examine the nasopharynx. Nor was any relationship found between hearing and the degree of tightness or flexibility of the postoperative palate¹². Drettner³ and Skolnik²³ investigated the preva-

lence of nasal obstruction in subjects showing evidence of middle ear infection. Drettner's findings led him to conclude that nasal obstruction probably facilitated occurrence of otitis media³. Skolnik found that 75% of his subjects who exhibited complete unilateral or bilateral obstruction of the nasal airway on an anatomical, catarrhal, or vaso-motor basis showed ear pathology²³. The same author also attempted to correlate hearing loss with multiple congenital anomalies, but no such relationship could be established. Spriestersbach et al.²⁴ reached the opposite conclusion in their study of 163 children with cleft lips and palates. They found that those subjects with cleft palate only and associated anomalies had a significantly greater incidence of loss and a greater magnitude of threshold deviation than did those subjects with the same type of cleft without associated anomalies²⁴.

Conclusions

A critical review of the information available on hearing loss in cleft palate patients reveals the hazard of equating or summarizing all of these reports simply because they have little in common in terms of experimental design. There was no uniformity in terms of age of the sample, type of clefts, or even in the criteria for evaluating hearing loss. For example, only two studies^{23, 42} pointed out that the incidence of hearing loss and middle ear infections in children with clefts varied as a function of age. However, neither of these studies recognized that a similar relationship might prevail in non-cleft children. Few investigations were designed to relate hearing loss and middle ear pathology to the type of cleft. Curiously, no data were available on the relationship between the side of the cleft and the side of the middle ear infection and/or hearing loss. A comparatively larger number of studies have been concerned with hearing loss as a function of the physical management of the cleft^{7, 8, 12, 17, 24}; however, the amount of data which has been collected on such questions as the effects of various techniques of surgical repair of the palate on post-operative hearing is limited.

Keeping these limitations in mind, the available information on hearing loss in

cleft palate patients may be summarized as follows:

1) The incidence of hearing loss in patients with cleft lips and palates is greater than that found in similar groups of patients without clefts^{3, 4, 9, 12, 18, 19}.

2) The most common type of loss in cleft palate patients is a bilateral, conductive loss^{3, 9, 20, 23}.

3) The hearing acuity of patients with cleft palates appears to vary as a function of age^{5, 6, 23, 24}; however the exact nature of this relationship has not been established.

4) There was a lack of agreement as to the relationship between hearing and the type of cleft^{3, 17, 24, 25}.

5) No definite relationship has been established between hearing loss and the severity of the primary deformity^{12, 23}.

6) There was a lack of agreement as to the relationship, if any, between hearing and the physical management of the cleft. There was some evidence that the incidence of hearing loss was lower in the surgically-treated patients than in those treated by prosthetic means.^{17, 24} However, there was some doubt as to whether this relationship remained constant²⁴. On this basis, no conclusions could be drawn about the importance of intact palatal musculature in preventing middle ear infections^{11, 22, 24}.

7) A minimal amount of evidence was available supporting the advantage of surgical closure of the palate with lengthening of the existing mucoperiosteal flaps over closure without lengthening in the effort to prevent middle ear infections¹⁷.

8) The relationship between hearing and the age of the patient at the time of surgical closure of the palate was not clear^{17, 24}, although there was some evidence that the earlier the closure the better the hearing¹². This question was further obscured by the influence of early

morphology on the choice of physical management and the age at which surgery, if any, was performed.

Perhaps the more valuable result of a survey of the published studies on hearing loss in cleft palate patients was not an emerging concept of what was known regarding the subject but rather a recognition of the myriad problems involved in trying to obtain meaningful answers. Some of these problems have already become apparent: the lack of agreement among investigators as to what constitutes a "hearing loss," the tendency of many studies to treat patients with varying anomalies as members of one population, the tendency of many studies to treat patients with varying anomalies as members of one population, the failure of many authors to recognize the influence that early morphology has on the physical management of the child with a cleft palate, etc.

In assessing the effects of specific forms of treatment, few investigators have been able to acquire pre-operative base-line records. Understandably, such assessments were not feasible in the young child. Because of this gap, correlations between specific treatment and post-treatment hearing must be guarded. Sampling requires greater homogeneity than is evident in the literature. Some authors have included patients with clefts who also had anomalies of the ear, such as microtia, and then reported results based on the *total* sample. This type of lapse in experimental design is at once the most common and the most glaring fault found in studies of hearing loss in cleft palate. Further, to create the illusion of large samples, the majority of authors have pooled the various sub-groups of clefts into a single population. Future clinical investigations concerned with conductive hearing loss in cleft palate must first segregate the patients into homogenous types of clefts and delineate the parameters that might influence the prevalence of middle ear infection and conductive hearing loss.

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(Continued on page 118)



Wine, Tranquility and the Physician

By SALVATORE P. LUCIA, M.D./SAN
FRANCISCO, CALIF.

An essential part of the human daily cycle is relaxation. In ancient and less stressful eras, man had cultural rituals which provided him relaxation and reflective time. Our modern frenetic and tension-filled days make this virtually impossible, and force us to turn increasingly to chemical relaxants and tranquilizers. Thus, these have become the second most frequently-used drugs the physician may prescribe for his patients¹. More often, the tranquilizer of choice needs to be mild and safe, especially if it is to be incorporated in a general regimen of long duration. For the latter purpose, the modern physician may consider the ancient dietary beverage, wine.

It is paradoxical that this suggestion is made today in hesitation. Wine has an ancient and honorable history as the oldest of medicines, and, as such, is among the safest and most universally used in recorded time. The reason behind the hesitancy is the break in history and the confusion caused by American Prohibition, with the result that: very few physicians of this generation have adequate knowledge of the psychodynamic effects of wine. Furthermore, textbooks and pharmacopoeias which dropped wine from their printed pages during prohibition still have not restored them following repeal.

Wine as Medicine

Wine for more than 40 centuries was the medicinal vehicle of choice, as well as a

medicine in its own right for inducing relaxation and sedation. Here are two Biblical precepts which show that the ancients knew well of wine's calming influence. One is: "Give strong drink unto him that is ready to perish, and wine unto those of heavy hearts" (Proverbs 31:6). The other is "Let him drink, and forget his poverty and remember his misery no more" (Proverbs 31:7). Considerable information on the medical use of wine is given in Homer's *Iliad* and *Odyssey* and in the writings of the great Greek physicians. In the Middle Ages, wine became the long-awaited panacea and the menstruum for that otherwise bizarre concoction known as theriac.

Modern research has verified and elucidated the ancient uses of wine as a medicine. Maynard A. Amerine, professor of enology at the University of California, considers wine to be a chemical symphony composed of ethyl alcohol, several other alcohols, sugars, other carbohydrates, polyphenols, aldehydes, ketones, enzymes, pigments, at least half a dozen vitamins, 15 to 20 minerals, more than 22 organic acids, and other grace notes that have not yet been identified².

Wine as a Tranquilizer

Furthermore, clinical and anthropological studies of the use of wine among selected patients and among certain populations has given scientific definition to many medicinal uses of wine, among them its

usefulness as a tranquilizer. Before we examine this, however, let us briefly define our terms.

A *tranquilizer*, pharmacologically, is an agent which reduces anxiety, lessens nervous and muscular tension, and retards the acuity of awareness; in short, it is a mild depressant. A *sedative* is an agent which banishes excitement and is capable of allaying irritation and assuaging pain. A *hypnotic-sedative* is a substance which in small doses reduces anxiety, and, in large doses, produces relative anesthesia.

Because tranquilizing drugs act upon the neuromuscular system, they may cause unpleasant side effects, depending upon the qualitative interactions of the host, his tissues, and the chemical nature of the constituents of the active pharmacodynamic medicinal agent. Tranquilizers may cause dizziness, drowsiness, nausea, or vomiting; some may produce epileptiform seizures. All tranquilizing agents carry some threat to psychic acuteness and physiologic function. A number of them—especially Rauwolfia and its alkaloids—potentiate the pharmacodynamic effects of barbituates, alcohol and opiates. Reserpine may cause mental depression in patients with low blood pressure and in some normal subjects. The phenothiazine derivatives potentiate hypnotics, narcotics, analgesics and anesthetics and may cause agranulocytosis. A significant incidence of Parkinsonism has been reported with thiopropazate. Some tranquilizers, such as meprobamate, may produce sensitizing anaphylactoid reactions, and potential addiction when large doses are used.

Consider Side Effects

The fact that most drugs used as tranquilizing agents can cause side effects does not, of course, mean that they should not be used; rather, they must be used with caution and knowledge. But, as in prescribing any medication, the physician must carefully weigh benefits to be derived against detriments which may appear. In considering wine as a tranquilizing medicament, the same criteria must apply. Both as scientists and as physicians, we must be objectively receptive to all revelations of modern research.

Scientific studies of wine have revealed

that its major pharmacologic effect is derived from its alcohols and aldehydes, but the depressant effect of the alcohols is greatly modified by many other of its polymeric constituents. Being the end product of fermentation of fruit, usually of grapes, wine, a dietary alcoholic beverage, can be considered by the physician to be a *natural* tranquilizer, as opposed to the synthetic tranquilizers, or drugs. Its total chemical constituents and attributes interact in a mildly pleasant alcoholic menstruum.

Pharmacologically wine is considered a hypnotic-sedative because of its alcohol content, but this is not an entirely accurate description. Wine is more than alcohol; its many other ingredients bring it into the category of tranquilizers.

"Chemical Symphony" Reduces Tension

Many studies of wine disclose that the ability of wine to reduce nervous tension is a result of its "chemical symphony." Greenberg at Yale, for instance, demonstrated that wine gives far more sustained and gently tranquilizing effects than does straight ethyl alcohol diluted with water to the same strength. Other observations and studies indicate that distilled spirits are absorbed more rapidly than wine and thus produce qualitatively and quantitatively more intense effects. The buffer effect of wine is enhanced by taking it with food, as at a meal.

Furthermore, unlike most other alcoholic beverages, wine holds in delicate balance a unique combination of attributes: its alcoholic content is low (12-to-20%), its pH is approximately that of the gastric milieu, and its absorption into the blood stream is slow and sustained, often lasting from one to several hours.

Lastly, wine is safe and physiologically sound. Even a healing gastric or duodenal ulcer is not necessarily a contraindication; often the patient benefits from its tranquilizing action. Neither is diabetes a contraindication, provided that only dry wines—mainly the table wines, which contain no sugar—are prescribed.

Appealing to Taste and Senses

The astute physician is always aware of the salubrious effects of wine. Carefully-timed and well-chosen, it can be appealing

indeed to the taste and senses, thus it is of far more value as a therapeutic adjuvant in promoting relaxation than is a hastily swallowed capsule. Wine can well alleviate those tensions that interfere with digestion, sleep, and other psychic functions. By using good judgment and resorting to careful observation of the patient's responses, the prescribing physician can determine the precise tolerated therapeutic dosage of wine for a given subject and his ailment.

As a tranquilizer, 4 oz. (one serving) of wine taken on an empty stomach, and 8 oz. (two servings) taken with food, are prescribed. Excellent results can be attained with a serving of dry sherry, dry vermouth, or champagne taken with appetizer foods 20 to 30 minutes before the main meal. The tannin compounds of the wine enhance the tranquilizing power by gently stimulating the appetite. Dry rather than sweet wines should be used for this purpose, since the natural sugars in sweet wines tend to depress appetite. A serving of dry (white, red, or rosé) dinner wine taken with the meal can further extend the tranquilizing effects.

Wine can do much to quell the psychic uncertainties of old age. It should be taken preferably a half-hour before bedtime. A single serving of port, sherry, or sweet vermouth thus applied can do much to allay the insomnia of the advancing years.

Plato, Osler et al

It was Plato who said that wine can "lighten the sourness of old age," and Sir William Osler called wine the "milk of old age." In a previous publication, I considered wine "Balm for the Autumnal Years."³ A single serving of port given to elderly patients at Cushing Hospital, Framingham, Mass., was reported by Kastenbaum to increase their sociability and acceptance of hospital life.⁴ Leake and Silverman record

that wine solves no emotional problems of the elderly but does "often enable oldsters to discount the discomforts and unpleasant sensations, ignore the actual or apparent ingratitude of children and adapt themselves to a disquieting or even frightening environment."

The field of geriatrics offers an example of the many interlocking occasions for the use of a gentle, non-toxic tranquilizing agent. Many and varied are the causes of tension which disturb the personalities of these worthy citizens. The physician's task is to select the most effective, appropriate, and gentle tranquilizer available—naturally wine—so that his patient can cope with these tensions and live out a long span in peace and gratitude.

In the rush of rapid pharmaceutical progress, the ages-old, established, inexpensive and safe medicine called wine is apt to be forgotten. So, too, in a post-Prohibition society, these ancient dietary beverages are still apt to be regarded over-emotionally and pseudomoralistically by the physician. Yet, the long history of the use of wine in medical practice and the modern scientific research confirming its values are gaining the attention of increasing numbers of physicians. And, for the biblically-minded, there is this very good advice from Ecclesiasticus (31:28) that wine "bringeth gladness to the heart, and cheerfulness to the mind."

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* * *

Committees on the medical aspects of sports who are planning meetings or conferences will find helpful assistance in "A Guide for Medical Evaluation of Candidates for School Sports" published by the AMA's Committee on the Medical Aspects of Sports, Department of Health Education. The pamphlet also assists the physician in conducting health examinations of the athlete.

Public Affairs Conferences in Washington to Draw Illinois Physicians, Wives

Representatives of the Illinois State Medical Society will gather in Washington, D. C., Jan. 31 to Feb. 2 for a Public Affairs Round-up. A special program for physicians and their wives on Jan. 31 will precede a two-day association public affairs conference sponsored by the Chamber of Commerce of the United States.

The ISMS part of the program will feature Neil Pierce, political editor of Congressional Quarterly, speaking on "Inside the 90th Congress;" Richard Wilson of Cowles Publications, "Midwest Political Perspective;" David Broder, Washington Post columnist, "Looking Toward 1968," and Raymond L. Hoewin, director of public affairs for the Effective Citizens Organization, "Public Affairs and the Physician."

The day will also include a breakfast session with AMA legislative briefing, a trip to Capitol Hill to visit congressmen and senators in their offices, and a congressional reception and dinner at the Sheraton-Park Hotel.

The association program on Feb. 1 and 2 will open with an address by M. A. Wright, president of the U. S. Chamber, and continue with a panel discussion on "Major Issues Facing the New Congress." Republican and Democrat leaders of both the House and Senate have been invited to participate in this session, which will be moderated by Arch N. Booth, executive vice president of the U. S. Chamber.

Leo Cherne, executive director of the Research Institute of America, will present the luncheon address on "Business Commitment in the Political and Legislative Field," which will be followed by a panel session on "Key Issues for Business Attention in 1967."

Highlight of the last day will be a panel discussion on "Government Economic Policies" by leaders in labor, management, government and universities. Senator-elect Charles Percy has been invited to give the closing address.

THE VIEW BOX

DIAGNOSIS AND DISCUSSION

(Continued from page 62)

Both renal collecting systems and portions of the ureters are outlined and appear normal. Our attention focuses on the superior aspect of the bladder which appears compressed. A faint gastric air shadow is displaced to the right. The descending colon gas pattern is somewhat shifted away from the left flank. A presumptive diagnosis is rupture of the spleen with intraperitoneal hematomata accounting for the displacement mentioned. Arteriography reveals a mottled vascularity within the body of the spleen resulting from intraparenchymal hemorrhage in the spleen. Films 3 and 4 reveal early opacification of the splenic and portal veins as a result of a traumatic splenic arteriovenous fistula which is almost a pathognomonic finding in splenic ruptures. The branches of the renal arteries appeared normal. The patient made an uneventful recovery after splenectomy.



Crippled Children's Clinics

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The division will count 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing service. There will be five special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- Feb. 1 Rock Island Cerebral Palsy—Foss Home, 3808 Eighth Ave.
- Feb. 1 Carlinville—Carlinville Area Hospital
- Feb. 1 Hinsdale—Hinsdale Sanitarium
- Feb. 2 Lake County Cardiac—Victory Memorial Hospital
- Feb. 8 Champaign-Urbana—McKinley Hospital
- Feb. 9 Macomb—McDonough District Hospital
- Feb. 9 Springfield General—St. John's Hospital
- Feb. 9 Anna—Union County Hospital
- Feb. 10 Chicago Heights Cardiac — St. James Hospital
- Feb. 10 Evanston—St. Francis Hospital
- Feb. 14 East St. Louis—St. Mary's Hospital
- Feb. 14 Peoria General — Children's Hospital
- Feb. 15 Chicago Heights General — St. James Hospital
- Feb. 16 Bloomington — St. Joseph's Hospital
- Feb. 16 Rockford—St. Anthony's Hospital
- Feb. 16 Elmhurst Cardiac—Memorial Hospital of DuPage County
- Feb. 21 Belleville—St. Elizabeth's Hospital
- Feb. 22 Springfield Cerebral Palsy—(Place to be announced)

- Feb. 22 Aurora—Copley Memorial Hospital
- Feb. 23 Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital
- Feb. 24 Chicago Heights Cardiac — St. James Hospital
- Feb. 28 Peoria General—Children's Hospital

Huggins Opens Cancer Lecture Series at University of Chicago

Dr. Charles B. Huggins, who shared the 1966 Nobel prize in physiology and medicine, was scheduled to begin the first in a weekly series of lectures to be given at the University of Chicago by 10 of the nation's leading cancer researchers.

Dr. Huggins, who is the William B. Ogden distinguished service professor and director of the Ben May laboratory for cancer research at the university, was to open the series Jan. 6 with a lecture on "Endocrine Restraint of Cancers."

Designed to inform medical practitioners, students and teachers in the Chicago area about the most recent developments in cancer research, the lectures are given at 5 p.m. in Room P-117 at Billings Hospital, 950 E. 59th St.

Dr. Robert W. Wissler, professor and chairman of the department of pathology at the university and coordinator of its cancer training program, announced the following schedule:

Jan. 13—"Feedback Control of Cholesterol Synthesis in Normal and Tumor Tissues" by Dr. Marvin D. Siperstein, professor of internal medicine, University of Texas Southwestern Medical School.

Jan. 20—"The Interaction of Normal and Malignant Human Cells in Culture" by Dr. Harry Eagle, professor and chairman, department of cell biology, Albert Einstein College of Medicine of Yeshiva University.

Jan. 27—"Do Cancer Cells Grow Faster?" by Dr. Renato Baserga, Samuel S. Fels Research Institute of Temple University.

**ILLINOIS
MEDICAL
ASSISTANTS
ASSOCIATION
REPORT**



Are Your Employees Members, Doctor?

Medical assistants throughout the country are benefiting from membership in the American Association of Medical Assistants. Many in Illinois are sharing these benefits by their membership in the Illinois Medical Assistants Association. Are your employees members of this organization, Doctor?

The objectives of this organization are to render educational service for the self-improvement of its members; to strive at all times to cooperate with the medical profession in improving public relations; and to inspire members to render honest, loyal, and more efficient service to the profession and to the public which they serve. This organization is non-union, non-profit. It is not, nor shall it ever become a trade union or collective bargaining agency. It has the approval and support of the American Medical Association and of the Illinois State Medical Society. It is the only organization for medical assistants that has this endorsement.

Your employees may join the Illinois Medical Assistants Association through the chapter in your county, or in counties where there is no recognized medical assistants association, they may join as a member-at-large through IMAA. Receptionists, secretaries, nurses, bookkeepers, technicians, medical librarians, medical office managers, and medical assistants, who have been employed at least six months by doctors of medicine, accredited hospitals, medical schools, medical laboratories, or by institutions accredited by the AMA are eligible for membership. Twelve physicians appointed by the Illinois State Medical Society serve the association as advisors and attend council and annual meetings.

Membership in IMAA offers your personnel the following:

- A. Educational Programs—consisting of leadership training seminars, professional symposiums, certification study groups and board examinations.
- B. Publications—A quarterly newsletter and a monthly bulletin informing members on educational materials and activities throughout the state and the nation.
- C. Annual Meeting—A three-day meeting comprised of House of Delegates proceedings, workshops, roundtable discussions, and lectures by leading medical figures.
- D. Annual National Convention in October.
- E. Insurance Group Plan—including major medical, life, accident, and sick leave benefits.
- F. Friendships and the interchange of ideas with medical assistants throughout the county, state, and the nation.

Most county chapters meet once a month for educational programs and lectures, and many are engaged in study groups covering the various phases of medicine which one must have knowledge of to pass the certification examination.

Why not encourage your personnel to look into the benefits they can derive from this organization? We invite them and you, Doctor, to attend a meeting in your county, or attend the State meeting in April. This year it will be held in Chicago.

For more information you may write:

The Illinois Medical Assistants
Association
360 N. Michigan Avenue
Chicago, Illinois 60601

Meeting Memos



Jan. 19—Cook County Hospital Division of Anesthesiology: 6:30 p.m. clinical anesthesia conference; 8 p.m. lecture on "Management of Thyroid Problems" by Sheldon Waldstein, M.D., professor of medicine, Northwestern University, in Karl Meyer Hall, Room 112, 720 S. Wolcott Ave., Chicago.

Jan. 21—"Connective Tissue Diseases" by Edmund F. Foley, M.D., at 11 a.m., Norwegian-American Hospital, 1044 N. Francisco Ave., Chicago.

Jan. 22-27—The American College of Physicians presents "Current Concepts in Blood Diseases" at the Fontainebleau Hotel, Miami Beach, Fla. Register with Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Jan. 25—"Dermatology for the General Practitioner," a postgraduate course presented by the University of Illinois College of Medicine from 9 a.m. to 4 p.m. at the Illini Union, 828 S. Wolcott St., Chicago. Topics include cutaneous infections (including syphilis); acne, seborrhea and rosacea; eczemas, and skin tumors.

Jan. 25—The Professional Group for the Study of Mental Retardation will present a discussion of "Delayed Speech in Children" by Paul Weiner, Ph.D., at 7 p.m. at the University of Chicago's Center for Continuing Education, 1307 E. 60th St., Chicago.

Jan. 30-Feb. 3—The American College of Physicians presents "Newer Aspects of Experimental and Clinical Allergy" at the Sheraton-Boston Hotel in Boston, Mass. Register with Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Feb. 1-2—The Cleveland Clinic Educational Foundation announces a postgraduate continuation course, co-sponsored by the Cleveland Chapter of the American Academy of General Practice, to be conducted at 2020 E. 93rd St., Cleveland, Ohio. Topics include celiac angiography; present status of radiation therapy; pelvic pain; corticosteroids in

therapy; cancer of the breast, diagnosis of coronary disease; current treatment of hypertension; infectious mononucleosis, needle biopsy; diagnosis of glaucoma; emotional problems of the college population; diagnosis of hypothyroidism and proper use of thyroid hormone; management of prostatic problem; treatment of ano-rectal problems; sarcoidosis, and myocardial revascularization surgery.

Feb. 3—The second Tumor Board conference sponsored by Northwestern University and affiliated hospitals will be conducted at 5 p.m. in the staff room of Chicago Wesley Memorial Hospital. "Diagnosis of Breast Masses" will be discussed by T. Howard Clarke, M.D.; Harold J. Matthies, M.D.; Robert Bouer, M.D.; Paul H. O'Brien, M.D., and Thomas C. Laipply, M.D.

Feb. 5-7—The Children's Hospital of Denver will present the Aspen Conference on the Newborn at the Aspen Institute for Humanistic Studies, Aspen, Colo. Topics include the fetus, the premature infant, respiratory distress syndrome, biochemical aspects of infant nutrition, and infection. Register with the Newborn Center of Children's Hospital, Denver, Colo.

Feb. 6-10—The American College of Physicians presents "Biochemical Mechanisms in Internal Medicine" at the Clopton Amphitheater of David P. Wohl Memorial Clinic, 4950 Audubon Ave., St. Louis, Mo. Register with Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Feb. 8—Forest Hospital Foundation and the Illinois Psychiatric Society will co-sponsor two lectures on current trends in psychiatry at 8 p.m. at the Illinois State Psychiatric Institute, 1601 W. Taylor St., Chicago. Zigmond M. Lebensohn, M.D., clinical professor of psychiatry at Georgetown University School of Medicine, Washington, D. C., will speak on "The Organization and Character of Soviet Psychiatry," and Isidore Ziferstein, M.D., research associate, Psychiatric and Psychosomatic Research Institute, Mt. Sinai Hospital,

Los Angeles, Calif., will discuss "Characteristics of Pathogenetic Psychotherapy."

Feb. 10-12—The Colorado Division of the American Cancer Society will present its first annual mid-winter cancer seminar at Vail, Colo. Topics include oral cancer, lung disease, pap smear, treatment with newer chemical techniques, uterine cancer, lymphomas and mammography—in addition to swimming, skiing, and sauna.

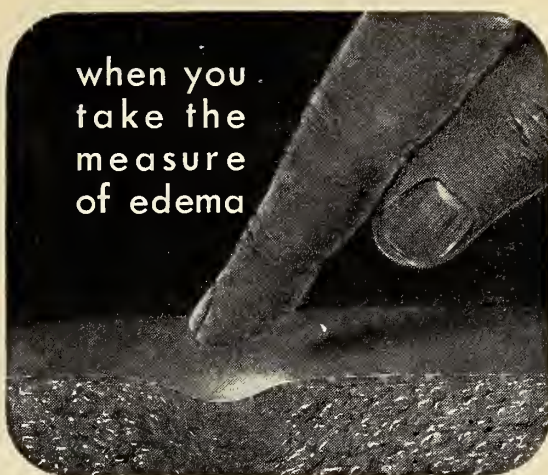
Feb. 15-16—The Cleveland Clinic Educational Foundation announces a postgraduate continuation course in electrophoresis and clinical chemistry to be conducted at 2020 E. 93rd St., Cleveland.

Feb. 15-17—The American College of Surgeons will conduct a sectional meeting at the Broadmoor Hotel, Colorado Springs, Colo., to discuss techniques of handling problems encountered in day-to-day practice. In addition to three days devoted to general surgery, there will be topics of special interest to orthopedic surgeons and neurosurgeons. Inquiries should be addressed to Dr. Woodrow L. Prickhardt, American College of Surgeons, 55 E. Erie St., Chicago 60601.

Feb. 18-22—The American Academy of Allergy will present a two-day postgraduate course on "Leukocytes" and "The Autonomic Nervous System" at the Holiday Inn-Riviera, Palm Springs, Calif. Additional information may be obtained from the American Academy of Allergy, 756 N. Milwaukee St., Milwaukee, Wis. 53202.

Feb. 23-24—The Sixth National Symposium of the Heart Association of Southeastern Pennsylvania will be conducted at Philadelphia's Sheraton Hotel. Subject of the meeting will be "The Metabolic Basis of Human Atherosclerosis."

Feb. 27-28, Mar. 1—A three-day conference on diabetes and obesity and the role of the oral hypoglycemic drug, phenformin, will be held by the New York Academy of Sciences at the Hotel Biltmore in New York.



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AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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How long will it take him
to recover from the flu
if he just doesn't care?



**Does he really care?
Is he alert, encouraged,
positive and optimistic
about getting out of bed
and back to work soon?**

**Or is he giving in to
the depressing impact
of confinement?**

**When functional fatigue
complicates convalescence,
Alertonic can help...**

Pleasant-tasting Alertonic is pipradrol hydrochloride—an effective cerebral stimulant whose gentle analeptic action helps counteract the apathy and inertia that so often delay convalescence—together with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding and encouragement together with Alertonic to help insure prompt response.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Alertonic[®]

Available Only On Prescription

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B₁) (10 MDR*), 10 mg.; riboflavin (vitamin B₂) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B₆), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.

†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

New Course in Neuromuscular Diseases of Children

The Cook County Graduate School of Medicine announces a two-week intensive course in Neuromuscular Diseases of Children with Special Emphasis on Management, to be given by Dr. Meyer A. Perlstein for the period of June 5 to June 16, 1967. This is an intensive didactic and clinical course designed for pediatricians, orthopedists, neurologists, psychiatrists and physiatrists interested in the care and treatment of children with neuromuscular handicaps. Emphasis will be placed on the practical clinical aspects of treatment and rehabilitation procedures. The course will include trips to demonstration clinics and treatment centers. The fee for the course is \$315 and since registration will be limited, applications should be made as far in advance as possible. For further information, write Mr. Eugene Meyer, Registrar, Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

* * *

More than 2,000 paid registrants are expected to attend the 1967 National Medical Symposium Mar. 9-11 in Miami at Fountainebleau Hotel.

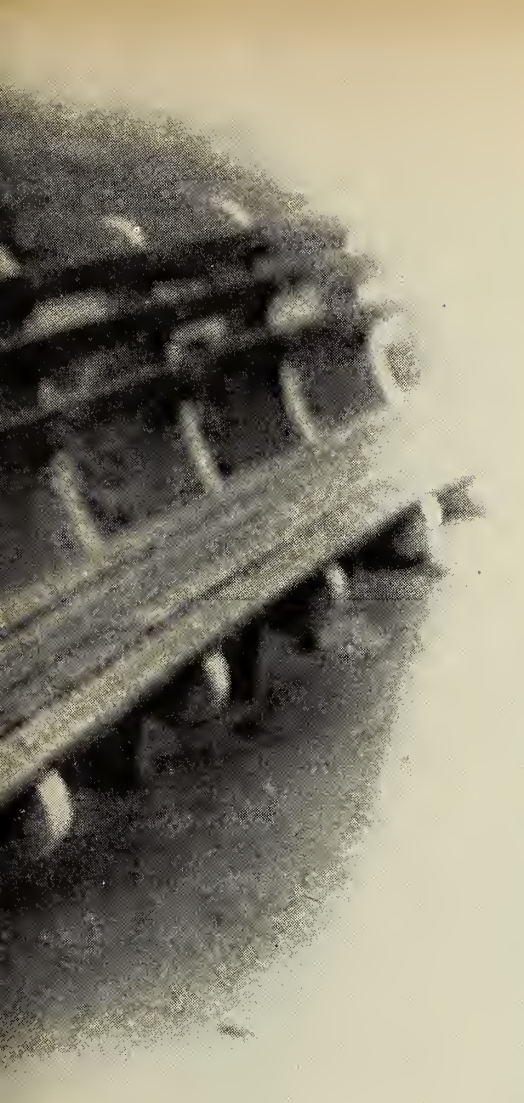
Two booklets published in October by the AMA Department of Investigation are now available for your information and waiting room use. "Health Quackery" is a 16-page pamphlet discussing in simple language quackery's methods and their results. "Chiropractic: The Unscientific Cult" is a penetrating analysis of chiropractic. It documents what chiropractic says it is and what it pretends to be able to do and proceeds to refute it. Single copies of each publication are 15 cents. Bulk quantities are available at lower prices.

* * *

Chairmen of state automobile safety committees will have the opportunity to attend future meetings of the AMA Committee on Medical Aspects of Automotive Safety. The Committee meets in various sections of the country and invitations will be extended to the state chairman from the state in which the meeting is being held and to chairmen from surrounding states. It is hoped that this effort will establish closer liaison between the AMA and state committees. As a further aid, the AMA will supply state chairmen with occasional reports on state and federal traffic legislation and other items on the medical aspects of traffic safety.

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NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

NEW SINGLE CHEMICALS

LEVOPROME Analgesic—non-narcotic Rx
Manufacturer: Lederle Laboratories

Nonproprietary Name: Methotrimeprazine

Indications: Relief of pain associated with chronic diseases such as arthritis and cancer, other acute pain, obstetrical analgesia, pre- and postoperative analgesia.

Contraindications: Concurrently with antihypertensive drugs, phenothiazine hypersensitivity, overdose of CNS depressants or comatose states, concomitantly with barbiturates, overt of incipient obstructive uropathy, severe cardiac or hepatic disease, clinically significant hypotension, and in children under 14 years of age.

Dosage: i.m.—10 to 30 mg. every 4 to 6 hours.

Supplied: 1 cc. ampuls; 10 and 30 cc. vials.

DUPLICATE SINGLE PRODUCTS

ESOPHOTRAST

Esophageal Cream Diagnostic—Contrast Media Rx

Manufacturer: Barnes-Hind Pharmaceuticals

Nonproprietary Name: Barium sulfate

Indications: Radiologic examinations of the esophagus

Dosage: As required

Supplied: Not stated

FUL-GLO Sterile

Ophthalmic Strips Diagnostic—Other Rx

Manufacturer: Barnes-Hind Pharmaceuticals

Nonproprietary Name: Sodium fluorescein

Indications: For staining the anterior segment of the eye when fitting contact lenses, in disclosing corneal injury, and in applanation tonometry.

Dosage: A touch on the conjunctiva or fornix with the moistened tip, as required.

Supplied: As strips containing 0.6 mg. Boxes of 100.

PERKê ONE Antiobesity Prep.—Amphetamine Rx

Manufacturer: B. F. Ascher & Co.

Nonproprietary Name: Dextroamphetamine sulfate

(Continued on page 91)

Precautions and adverse reactions: The transitory drowsiness which occur with hydroxyzine HCl usually disappears spontaneously within a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Voluntary motor activity, including rare instances of tremor and convulsions, has been reported, usually on higher than recommended dosage. **Hydroxyzine HCl may potentiate barbiturates, narcotics such as meperidine, and other CNS depressants.** In canine use, dosage for these drugs should be decreased as much as 50%. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been minimal. When used intravenously, if given undiluted, minimal amounts of hemolysis (2-3 grams of liberated hemoglobin) will occur. If diluted with 50 cc. of normal saline and given during a period of 15 minutes or more, this phenomenon does not occur. Due to the slow and infrequent phlebitis, the rate of injection must not exceed 25 mg. per minute. A single I.V. administration in excess of 50 mg. is not recommended. Particular care should be used to avoid injection only into intact veins; a few instances of digital necrosis occurring distal to the injection site have been attributed to inadvertent intra-arterial injection or periarterial extravasation, both of which should be avoided. **Use in Pregnancy:** When administered to rats at high dosage, hydroxyzine induced fetal abnormalities. Until human clinical data are available to adequately establish safety in early pregnancy, hydroxyzine is contraindicated in early pregnancy.

when congestion is complicated by sulfa-susceptible
bacterial invaders in the
upper respiratory tract...



re-enforce your decongestant therapy

prescribe economical **Trisulfaminic[®]**

Each tablet contains:

Triaminic[®] 25 mg.
(phenylpropanolamine hydrochloride 12.5 mg.,
pheniramine maleate 6.25 mg., pyrilamine
maleate 6.25 mg.)

Trisulfapyrimidines, U.S.P. 0.5 Gm.
(sulfadiazine 0.167 Gm., sulfamerazine
0.167 Gm., sulfamethazine 0.167 Gm.)

DORSEY LABORATORIES • a division of *The Wander Company* • **LINCOLN, NEBRASKA**

PHARMACOLOGY: Triaminic decongests and promotes drainage of nasal and paranasal passages, and prevents any further histamine-induced damage; the triple sulfonamides inhibit susceptible bacterial invaders. **INDICATIONS:** For congestion and infection of the upper respiratory tract caused by sulfa-susceptible organisms. **DOSAGE:** Adults: 2 to 4 tablets initially, followed by 2 tablets (concluded on facing page) every 6 hours. Medication should be continued until patient has been afebrile for 3 days. (concluded on facing page)

New Pharmaceutical Specialties

(Continued from page 89)

Trisulfaminic continued

ADVANTAGES: The advantages of Trisulfaminic in upper respiratory infections are: palatability of suspension; freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. **CONTRAINDICATIONS:** Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. **WARNING:** Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. **PRECAUTIONS:** Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. **ADVERSE REACTIONS:** As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. **PACKAGE INFORMATION:** Trisulfaminic Tablets: Supplied in bottles of 100 tablets. **CAUTION:** Federal law prohibits dispensing without prescription.

DORSEY LABORATORIES
a division of The Wander Company
LINCOLN, NEBRASKA

Indications: In mild depressive states characterized by apathy, lethargy and psychomotor retardation, orthostatic hypotension, narcolepsy, and non-arteriosclerotic parkinsonism, adjunct in weight reduction and alcoholism.

Contraindications: Hypertension, advanced coronary artery disease, hyperthyroidism, hyperexcitability, involutional melancholia or agitated depressions.

Dosage: One capsule, taken in the morning.

Supplied: In bottles of 100 and 500 red/clear capsules

COMBINATION PRODUCTS

AASQUEL Tablets Antispasmodic Rx
Manufacturer: Brown Pharmaceutical Co.

Composition:

Hyosciamine sulfate	0.1075 mg.
Atropine sulfate	0.0195 mg.
Hyoscine hydrobromide	0.0070 mg.
Phenobarbital (1/4 gr.)	16.2 mg.

Indications: Nausea, vomiting, gastritis, gastrointestinal spasms, hyperacidity, ulcerative colitis, chronic cholecystitis, frequency of urination, nocturnal enuresis, mild hypertension, motion sickness.

Contraindications: Glaucoma, advanced hepatic or renal disease, or hypersensitivity to one of the components.

Dosage: One or two tablets 3 or 4 times daily.

Supplied: In bottles of 100 and 1000 tablets.

PERKê TWO Antiobesity Prep.—Amphetamine Rx

Manufacturer: B. F. Ascher & Co.

Composition: Dextroamphetamine sulfate 15 mg.
Amobarbital 60 mg.

Indications: In mild depressive states characterized by apathy, lethargy and psychomotor retardation, orthostatic hypotension, narcolepsy and non-arteriosclerotic parkinsonism, adjunct in weight reduction and alcoholism.

Contraindications: Hypertension, advanced coronary artery disease, hyperthyroidism, hyperexcitability, involutional melancholia or agitated depressions.

Dosage: One capsule, taken in the morning.

Supplied: In bottles of 100 and 500 red/yellow capsules.

PERKê THREE Antiobesity Prep.—Amphetamine Rx

Manufacturer: B. F. Ascher & Co.

Composition:

Amphetamine sulfate	15 mg.
Thyroid	195 mg.
Atropine sulfate	0.36 mg.
Aloin	16 mg.
Phenobarbital	16 mg.

Indications: Adjunct in the dietary treatment of obesity.

Contraindications: Agitated prepsychotic states, anxiety states, hyperexcitability, undue restlessness, parkinsonism, pyloric obstruction, prostatic hypertrophy, intolerance to anticholinergic drugs, nephrosis, adrenal insufficiency, hypopituitarism or hypogonadism, nausea or vomiting.

Dosage: One capsule, taken in the morning.

Supplied: In bottles of 100 and 500 red/pink capsules.

(Continued on page 109)

Treat the cough as well as the cold

Controls both productive and nonproductive cough, without suppressing productive cough • decongests the airways • helps liquefy secretions responsible for irritation • provides prompt symptomatic relief of allergic symptoms • is well tolerated • rarely causes constipation. **Average Dosage:** Adults, 1 teaspoonful. Children 6-12 years, ½ teaspoonful; 3-6 years, ¼ teaspoonful; 1-3 years, 10 drops; 6 months to 1 year, 5 drops. Administer after meals and at bedtime with food. **Caution:** Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not

Endo

ENDO LABORATORIES INC., Garden City, N.Y.

exceed 3 days. Hycomine Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur. Patients should be cautioned not to drive a car or operate machinery should they become drowsy while taking Hycomine Syrup. (Hydrocodone may be habit-forming.)

Each teaspoonful (5 cc.) contains: hydrocodone bitartrate (Warning: May be habit-forming) 5 mg. and homatropine methylbromide 1.5 mg. (Hycodan®), antitussives; pyrilamine maleate 12.5 mg., antihistamine; phenylephrine hydrochloride 10 mg., decongestant; ammonium chloride 60 mg. and sodium citrate 85 mg., expectorants; with methylparaben 0.13% and propylparaben 0.02% as preservatives, in a highly palatable cherry-flavored vehicle. U. S. Pat. 2,630,400

On oral Rx where state laws permit.

Hycomine®

SYRUP



Next time you catch a cold coughing

New Pharmaceutical Specialties

(Continued from page 91)

NEW DOSAGE FORMS

AVC/Dienestrol

Suppositories Antiinfectives—Vaginal Rx

Manufacturer: The National Drug Co.

Composition: Each suppository contains:

Dienestrol	0.70 mg.
Sulfanilamide	1.05 Gm.
Aminacrine HCl	14.0 mg.
Allantoin	140.0 mg.

Indications: For atropic vaginitis complicated by non-specific mild to moderate infection in late menopause or post-menopausal women; to relieve or eliminate symptoms such as pruritus, burning, leukorrhea, dyspareunia, or dysuria, if from urine over inflamed tissue.

Contraindications: Not to be used by patients sensitive to sulfonamides, with, or a history of, breast or genital tract carcinoma, or depressed liver function.

Dosage: Average dose: 1 suppository intravaginally once or twice daily.

Supplied: In boxes of 12 suppositories with applicator.

OMNIPEN Antiinfectives—Penicillin Rx

Manufacturer: Wyeth Laboratories

Nonproprietary Name: Ampicillin

Indications: Urinary, respiratory, and gastrointestinal tract infections caused by: *Shigella*, *Salmonella*, *E. coli*, *H. influenzae*, *P. mirabilis*, Beta-Haemolytic streptococcus, nonpenicillinase-producing *Staphylococcus aureus*, *Diplococcus pneumoniae*, and *Streptococcus fecalis* and viridans.

Contraindications: Hypersensitivity to penicillin and in infections caused by penicillinase-producing bacteria.

Dosage: Adults—250 to 500 mg. q6h.
Children—(under 13 years)—100 to 200 mg/Kg./day in divided doses every 6 or 8 hours. The total dose should not exceed the recommended adult dose.

Supplied: Suspension—Bottles containing 4 Gm. or 2 Gm. to be mixed with water to make 80 cc.

RANDOMYCIN Syrup Antibiotic—B & M Spectrum Rx

Manufacturer: Pfizer Laboratories

Nonproprietary Name: Methacycline HCl

Indications: Infections caused by susceptible strains of Gram-positive and Gram-negative organisms: pneumonia, respiratory tract, genito-urinary tract, soft tissue, ophthalmic, and gastro-intestinal infections.

Contraindications: Reduce dosage in renal impairment.

Dosage: Adults: 600 mg. daily, in divided doses.
Children: 3 to 6 mg/lb. body weight, daily, in divided doses.

Supplied: In 2 oz. and 16 oz. bottles.

DIARRHEA MUCOUS COLITIS DIVERTICULITIS SPASTIC URETERITIS BLADDER SPASM

are relieved with.....



Trocinat[®]

BRAND THIPHENAMIL HCl

Minimum dosage 400 mg., q. 4 h. until relief is constant, adjust maintenance dosage.

A therapeutic blood level cannot be obtained with small dosage. Trocinat is metabolized and eliminated in the urine as harmless degradation products—a safety factor. Sixteen years of clinical usage with the absence of untoward effects establishes the safety of Trocinat. The autonomic nervous system is not involved in its prompt action.

NOW AVAILABLE IN 2 STRENGTHS,
100 mg. and 400 mg.
PINK SUGAR-COATED TABLETS

Literature and samples available.

WM. P. POYTHRESS & CO., INC.
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Manufacturers of ethical pharmaceuticals since 1856



Now, now, Mrs. Forsythe, we've never lost a cold patient yet.

When she's experiencing acute discomfort from cold symptoms, it's small wonder the patient becomes distressed about her condition.

She will breathe easier when you prescribe Novahistine LP.

Novahistine LP is a long-acting decongestant that helps restore normal mucus secretion and ciliary activity—physiologic mechanisms which prevent infection of the respiratory tract. A dose of two tablets taken in the morning and repeated in the evening will usually keep air passages clear for 24 hours.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution patients who operate machinery or motor vehicles that drowsiness may result.

Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE[®] LP

For relief of nasal congestion.



PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

Saxon

President's Page

(Continued from page 21)

adequate coverage of medical care for the poor, health hazards in our society, etc.

In the main, the idea is that these medical complexes which have been established by the "Great Society" should be under the leadership of the medical schools and that they are best qualified to lead the country toward a better system of health care. I feel that this is nothing less than the truth. I feel that the medical profession, the medical society especially, should take the leadership in the health programs, in the health care, in the advice to the federal government rather than non-medical people. It is about time that medicine rose up to its duties and responsibilities. It's about time that medicine has regained its birthright.

Another question is who should police the medical profession? Who should pass judgment on the doctor's competence? Without a doubt, this certainly is the responsibility of the medical society and the medical profession itself. Most state medical societies have no effective way of disciplining members for incompetence. Yet the problem of incompetent physicians must

be met. There is a surgeon, for example, with a progressive tremor, or the outstanding medical man who has failed to keep abreast of modern methods, or the physician whose competence is undermined by liquor or drugs. The most logical place to weed out the incompetent physician is in the hospital. There should be some machinery developed where these men can be brought before a committee and their problems and their staff position solved.

I realize that this is a very delicate situation. I also realize that this is a difficult task. Nevertheless, we must again assume the responsibility. We must take hold of the reins. We are the ones who have to be worried about the image of the doctor. We are the ones who are constantly being criticized in the press, radio and television. We are the ones, together with the medical societies, the hospitals, and the Board of Examiners, who should be responsible for the disciplining of incompetent physicians. If we don't do it, the lay people and/or the government will no doubt step in and do the job for us.

Millis to Speak at SAMA Meeting

Dr. John S. Millis, whose name has been given to the report of a three-year study on graduate medical education, will address a Student American Medical Association symposium Feb. 10 at Chicago's Sherman House.

Dr. Millis was chairman of the Citizens Commission on Graduate Medical Education, which was established by the American Medical Association to explore ways in which high standards of medical education can be maintained.

The symposium is co-sponsored by the Illinois State Medical Society and the Chi-

cago Medical Society. The SAMA chapter from Stritch School of Medicine will be host at a reception at 7:15 p.m., in the Exhibit Hall. Dr. Millis will speak at 8 p.m.

The symposium is open to members of the five Illinois SAMA chapters, to members of the ISMS and CMS Boards of Trustees, and to all other interested physicians.

Reservations should be made by Feb. 1 with the Division of Public Relations and Economics, ISMS, 360 N. Michigan, Chicago.



For the anxiety- insomnia cycle



When your patient's worries, apprehensions or other manifestations of acute and chronic anxiety interfere with his sleep, a bedtime dosage of Librium (chlordiazepoxide HCl) helps break the anxiety-insomnia cycle. Added to the routine t.i.d. dosage that helps calm the patient during the day, Librium (chlordiazepoxide HCl) h.s. can help relax him at night, encouraging the restful sleep that comes from relief of anxiety. Next morning the patient usually awakens refreshed and alert, without a hang-over.

In addition to providing prompt and effective action over a wide range of emotional disorders, Librium (chlordiazepoxide HCl) has a wide margin of safety. When used to relieve anxiety-induced insomnia, it may eliminate the need for hypnotics.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Warn against hazardous occupations requiring complete mental alertness. Use caution in administering to addiction-prone patients or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In elderly and debilitated and in children over five, limit dosage to smallest effective amount, increasing gradually as needed and tolerated. In general, concomitant use with other psychotropics is not recommended. Paradoxical reactions have been reported in psychiatric patients and hyperactive aggressive children. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Observe usual precautions in presence of impaired renal or hepatic function, impending depression and suicidal tendencies.

Adverse reactions: Drowsiness, ataxia and confusion may occur, especially in elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. Syncope occurs rarely. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis, jaundice and hepatic dysfunction) may develop occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy. Individual maintenance dosages should be determined.

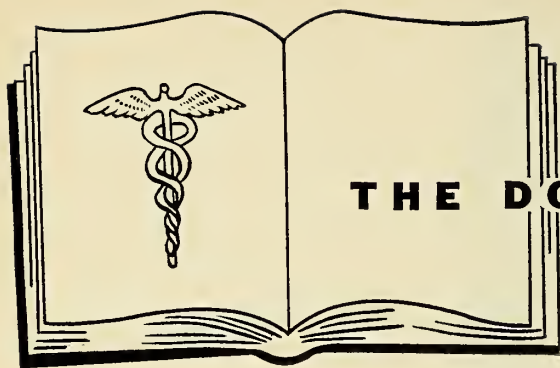
Dosage: Oral — Adults: Mild to moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d.

Supplied: Capsules, 5 mg, 10 mg and 25 mg—bottles of 50.

when anxiety
interferes with sleep
Rx Librium®
(chlordiazepoxide HCl)
one cap. t.i.d. plus h.s.



Roche Laboratories
Division of
Hoffmann-La Roche Inc.
Nutley, N.J. 07110



THE DOCTOR'S LIBRARY

EARLY MANAGEMENT OF ACUTE TRAUMA.
Edited by Alan M. Nahum. 336 pages.
The C. V. Mosby Co., St. Louis, Mo.,
1966.

As stated in the preface, this book is a compilation of material which was presented at a symposium, entitled, "Early Management of Acute Trauma," which was held at the University of California in Los Angeles in February of 1965.

The editor states that the objective of the book is to provide a practical background which can be of help for the physician who has the responsibility for early care of patients after acute trauma. The objective of the editor has been achieved in a reasonable fashion, considering that there are multiple authors involved in this publication. There is some variation in the emphasis placed upon certain chapters as judged by the number of pages devoted to certain subjects. For example, only three pages are devoted to Chapter 6, "Radiologic Aids to Rapid Diagnosis." There is considerable duplication of information in two chapters, entitled, "Injury to the Spine" and "Spinal Cord Injuries." At the same time, there are some highly useful and lucidly written chapters. There is excellent material presented in the chapter on Chemotherapy and Chemoprophylaxis, which provides an excellent outline of the indication for the use of and selection of antibiotics in the management of injured patients. The chapter on Cardiac Arrest and Resuscitation is well organized and well presented and is followed by a competent description of the management of airway and ventilation problems.

The book includes a description of first aid management, a discussion of psychiatric problems in the injured, and chapters on Craniocerebral, Maxillofacial, Abdominal, and Genitourinary injuries. There is discussion of Acute Trauma in Infants and Children that includes a discussion of the management of burns. There is a detailed and competent discussion of the management of fractures, although one has trouble correlating a large number of case histories with pictures of x-rays which accompany the text. However, on the whole, the illustrations are of high calibre and are well selected.

A competent job of editing has been performed, so that the text reads smoothly. Three of the pictures of roentgenograms in the chapter on Abdominal Injuries are mislabeled. Appropriate emphasis is placed on resuscitation of patients and a practical guide in management is achieved. The book is recommended to physicians who are interested in the management of the traumatized patients, and it may well be of considerable value to resident surgeons in training.

John M. Beal, M.D.

DIAGNOSIS AND THERAPY OF THE GLAUCOMAS. Bernard Becker, M.D. and Robert N. Shaffer, M.D., F.A.C.S. Second edition. 443 pages, 228 illustrations, 5 color plates. St. Louis, Mo., C. V. Mosby Co., 1965. \$18.50.

Some four years ago the authors joined forces to produce the first edition of this text. This was a most happy conjunction since both men are world authorities in

their field. Further since Dr. Becker's interests are primarily in the basic mechanisms of ocular secretion and flow, and since Dr. Shaffer's chief interests are clinical in nature, they complemented each other to produce a text that quickly became the standard in the field.

However, in the intervening four years new knowledge has accrued in the field of glaucoma and it became apparent that a new edition was necessary. Two examples of this are: The relationship of steroids to glaucoma and the concept of glaucoma as a heritable disease transmitted in a recessive fashion. In addition the new edition carries illustrations from Shaffer's "Stereoscopic Manual of Gonioscopy" which adds pertinent clinical information to the text.

All ophthalmologists will find this a most useful and instructive textbook and it can be read with profit by any physician who would like an understanding of one of the most common diseases of the older patient.

David Shoch, M.D.

ATLAS OF CATARACT SURGERY. John M. McLean, M.D., F.A.C.S. First edition. 130 pages. St. Louis, Mo., C. V. Mosby Co., 1965. \$20.00.

By far the most common disease of the aged eye is cataract and since there is no medical treatment for cataracts, *pari passu*, the most common operation performed by ophthalmic surgeons is cataract extraction. Consequently, this is a subject about which there is constant interest and discussion. It is particularly pleasant to read this new text on the subject because the author is a surgeon of great repute and has devoted a considerable portion of his life to the development of a safe, effective technique of cataract surgery and in addition has been a constant teacher of young residents so that his thoughts and concepts have been crystallized by the crucible of resident evaluation and criticism.

His experience as a teacher is quite evident in this book. The language is concise and simple, the illustrations are sharp line drawings with shading as needed, and the steps in the surgery have been clearly indicated with a minimum of confusing detail. It is good to read his conservative views on cryogenic extraction of lenses and the final presentation on congenital cataract

is a delight. He omits the usual review of dozens of unsuccessful procedures and states simply, "There are many surgical approaches to congenital cataract, but only one (aspiration) will be discussed since its results have been so superior to any of the others."

Residents in ophthalmology particularly will find this their most useful guide to developing a safe, effective technique for cataract surgery but there is good to be derived from it by surgeons of all degree.

David Shoch, M.D.

RADIOGRAPHIC EXAMINATION IN BLUNT ABDOMINAL TRAUMA. James J. McCart, M.D. W. B. Saunders Company, 1966.

The ever increasing problem of diagnosis and prompt treatment of blunt abdominal trauma has prompted Dr. McCart to write this monograph. His discussion and demonstration of the scant film findings in trauma to the solid organs and hollow viscera is accurate and well demonstrated by numerous illustrations and line drawings. He is particularly thorough in his description of intraperitoneal and retroperitoneal collections of blood; the recognition of which is extremely valuable in early accurate roentgen diagnosis.

Unfortunately, the author's illustrations in the use of arteriography in renal and splenic injury are poor. The cases he chooses to demonstrate are lacking in detail and in definite diagnosis characteristics. (For example, a renal arterio-venous fistula on p. 177 is diagnosed with inappropriate roentgen evidence.)

A good discussion of traumatic rupture of the diaphragm and lower urinary tract is included and worth the reader's time. I would recommend this book to radiology residents and trauma surgeons as a good basic text on this subject with the exception noted above.

Leon Love, M.D.

SYMPOSIUM ON CATARACTS. TRANSACTIONS OF THE NEW ORLEANS ACADEMY OF OPHTHALMOLOGY. The C. V. Mosby Co., St. Louis, Mo. 1965. 340 pages, \$19.50.

The annual meeting of the New Orleans Academy of Ophthalmology has become a fixture in American ophthalmology and its attractiveness is only partly explained by

the charm and warmth of the host city. The chief reason for its national prominence is the exhaustive detail with which a subject is covered and the caliber of the people who take part in the symposia.

This meeting on cataracts held in February, 1964, was no exception. The panelists consisted of seven authorities in the field: Boyd of Panama, Christensen from Oregon, Irvine of California, McCaslin and McDonald from Pennsylvania and McLean and Troutman from New York. The subjects cover the entire field of cataract surgery and will be of interest to all ophthalmologists since this is without doubt their favorite operation.

If there is one subject that is of consuming interest in the field it is the prevention and management of complications. This topic is particularly well done by Boyd in chapters 11 through 13 of this book.

On the other hand perhaps the most neglected subject in cataract surgery is the management of the aphakic patient. Troutman and Willard do a masterful job of presenting this topic under four headings: surgical variables, physiological variables, spectacle variables and subjective variables. It is unfortunately true that many ophthalmologists feel that their job is over when the post-operative eye is quiet and a spectacle prescription written. This chapter will help them to appreciate the visual problems of the aphakic patient. This chapter (and the book) end with a most important and sobering statement: In over 500 patients fitted with intra-ocular lenses "Barraquer has documented a complication rate of about 26%. . . . In his group more than 125 eyes suffered full or partial loss of vision while the remaining healthy eyes gained little by comparison." Let us hope that this will settle all discussion of the tenuous merits of these devices.

David Shoch, M.D.

ARTERIOGRAPHY, PRINCIPLES AND TECHNIQUES EMPHASIZING ITS APPLICATION IN COMMUNITY HOSPITAL PRACTICE. Joseph L. Curry, M.D. and Willard J. Howland, M.D. 328 pages. W. B. Saunders Co., Philadelphia, Pa., and London, England, 1966.

Curry and Howland from the Department of Radiology of the Ohio Valley General Hospital in Wheeling, W. Va., have utilized their experience in a community hospital as the foundation for this introductory monograph on basic principles and techniques of arteriography. The material is presented in a clear, concise manner with each section well illustrated. The illustrative angiograms are easily readable and informative.

As they should be, complications and the precautions necessary to avoid them, are repeatedly emphasized in each section. There is over-emphasis and over-simplification of catheter techniques with little attention to trans-lumbar, retrograde injection and direct puncture arteriograms. This tends to disregard the extensive experience of others with the direct procedures which have an excellent record of safety and simplicity. Otherwise diagnostic techniques used for visualization of regional areas of vasculature of current clinical interest are well covered.

The text is easy reading for the student, house officer or physician interested in learning what may be expected when a patient is referred for arteriography. For the beginning arteriographer the text must be supplemented, as the authors recommend, by observation and participation in arteriographic procedures.

Julius Conn, Jr., M.D.

* * *

At its recent Clinical Meeting in Las Vegas, the American Medical Association urged that secondary schools make every effort to offer and attempt to interest all students in driver education courses, and to provide as many students as possible with practical behind-the-wheel training under actual road conditions.

OBITUARIES

Mrs. John Neal, wife of John W. Neal, executive administrator of the Chicago Medical Society, died December 13 in Evanston Hospital. She was a former laboratory technician at Cook County Hospital.

***Dr. William O'Neal**, past president of the North Suburban branch of the Chicago Medical Society, died Nov. 29 in Evanston. A graduate of Loyola University and the University of Illinois College of Medicine, he had been a doctor for 60 years and was an attending physician on the staffs of Evanston and St. Francis Hospitals.

***Dr. Maurice W. Sbertoli**, Chicago, died November 25 at the age of 59. He was a graduate of St. Louis University and served his internship and residency at St. Mary's Hospital in St. Louis.

***Dr. Gordon S. Campbell**, director of the Lakeview Medical Center, died December 26 at the age of 45. He was a member of the Chicago Medical Society and its North Shore branch, and the American Medical association.

Dr. Leon H. Strong, Glen Ellyn, died December 14 of leukemia from which he had suffered since 1957. Dr. Strong, who specialized in research on the human circulatory system, had been a teacher since 1947 at the Chicago Medical School where he was professor emeritus of anatomy and associate professor of cardio-vascular research. In 1932, he developed a method of viewing the small blood vessels of the human embryo. His research resulted in better understanding of blood vessel development as applied to the development of the human brain.

Dr. Charles H. Swift, Chicago died at the age of 85 on November 17. He was a professor emeritus of anatomy at the University of Chicago.

***Dr. William A. Thomas**, a Chicago physician for 50 years, died December 17. A specialist in internal medicine, he taught at Rush Medical College from 1918 to 1958. Dr. Thomas was a member of the Adventurers Club and was a member of expeditions to the Arctic in the 1940s and 1950s.

* *Member of Illinois State Medical Society.*

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MEDICAL PROGRESS (Continued from page 69)

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ACKNOWLEDGMENT

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New Single Unit Ultrasonic Cleaner Is Introduced by Dynasonics Corp.

The Dynasonics Corporation has introduced a new "Consolette" Model ultrasonic cleaner, containing generator and tank in a single unit.

Constructed of all-stainless steel, the cleaner features a design which allows the unit to be counter-sunk, with the control panel positioned at counter level. This provides easy access for the operator, as well as splash back protection.

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The "Consolette" is specially designed so that the drainage can be accomplished without removal of the system. The "Consolette" also may be connected directly into wastelines if desired.

Inside diameter of the five gallon tank is 14"L x 10"W x 9 1/2"D. Units are available with 200 or 300 watt output at 40 KC, 110/220 volts. The price for standard cleaners is \$690.

Optional accessories for the "Consolette" include stainless steel covers and baskets. Complete information is available from Dynasonics Corporation, One Ireland Place, Amityville, N. Y.

EDITORIALS



THE GOLDEN YEARS

Many of the problems associated with growing old are psychological and could be avoided by knowing what to expect of the future and making plans ahead of time. It is well-known that after age 65 most worries stem from concern over health, finances, and social insecurity. Loneliness and a feeling of having outlived one's usefulness accounts for much of the mental depression of older people.

Seidel in his book, *Rehabilitation of Handicapped*, compiled a set of rules for oldsters. He recommends that every one:

"1. Continue to work at his vocation and retain his accustomed position in society as long as possible.

"2. Avoid sedentary habits and inactivity, continuing with whatever open air activities or hobbies he may be accustomed to; if he has none he should acquire some.

"3. Engage in systematic daily exercises designed to prevent or overcome physical deformities; these should include the practice of deep breathing.

"4. Make full use of helpful devices such as hearing aids, eye glasses, and dentures.

"5. Keep face and body free from unsightly blemishes.

"6. Always maintain self-respect and dignity; be jealous of his appearance, dress neatly, and retain good manners.

"7. Continue contact with lifetime friends, and learn to make new ones.

"8. Follow good body hygiene and sanitation; eat sensibly, a well balanced diet of nourishing food.

"9. Seek medical advice at frequent intervals and carry out in full the advice given.

"10. Above all, avoid despair and an outlook of futility and 'Fear God and keep His commandments; for this is all that is required of man.'"

Old age is not bad, especially if you consider the alternative.

Theodore R. Van Dellen, M.D.
Editor

HUNGER AND SATIETY

The physiology of hunger and satiety is a subject that has too long been ignored by physicians who treat obesity. This is the view of Dr. Jean Mayer, professor of nutrition at Harvard Medical School. Dr. Mayer has shown that unilateral destruction of the ventro-medial nucleus can trigger slowly developing obesity in the rat. He postulated the presence of chemoreceptors in the ventro-medial center of the hypothalamus which have special affinity for glucose and are activated by it. He found an excellent correlation between over-all glucose utilization and the presence or absence of hunger

feeling and gastric-hunger contractions. A high level of glucose utilization was found to coincide with satiety, while a feeling of hunger and stomach contractions were seen only in states of low glucose utilization.

Dr. Mayer pointed out that there has been a dearth of systemic data concerning the sensory aspects of hunger and satiety in men. In a recent study conducted in 800 obese and non-obese adults and adolescents, he found a great variety of sensations, including rumbling feelings of emptiness, pain, and nausea localized in the gastric area, which these subjects recognize as hunger signals. Other subjects experienced sensations of oral nature, such as salivation, dryness and unpleasant tastes. Headaches, nervousness, dizziness, and irritability were present in a high percent of cases. Significantly these symptoms were noted more frequently in males than females. These observations are well known to those on the distaff side, who have observed them in their husbands before the evening meal, particularly after a hard day of toil.

Dr. Mayer draws some interesting conclusions regarding the practical management of patients with obesity. He believes that a food reducing diet should not make a patient feel too hungry, and advocates the shifting of allotted calories to the period of peak hunger. He states that anorexigenic drugs should not be of the long acting type, but the fast acting type should be given just before periods of maximum hunger. He urges that doctors carefully question each obese patient to determine the patient's characteristic hunger pattern.

He concludes that there are large gaps in our knowledge of the physiological mechanisms of food intake regulation. A better correlation needs to be established between metabolic phenomena, neurological activity, and sensations in relation to the regulation of food intake.

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Harvey Kravitz, M.D.

The HOSPITAL OF CHOICE

North Shore Hospital, a 65-year-old psychiatric facility located on Lake Michigan in Winnetka, Illinois, is an intensive care hospital.

An open staff institution, it provides, through its house and attending staff, a total range of psychotherapies and those related activities which round out a comprehensive treatment program.

A new Half Way Hall, situated in the hospital, has been opened to provide relative freedom of movement in an environment designed to stimulate recovery and provide a necessary phase of interim residence.

A completely open section is a feature of North Shore Hospital's residential plan.

An adolescent program offers boys and girls of high school age a closely-structured program of daily care, with daily classroom attendance and individual tutoring emphasized.

The adjunctive therapies are manned by certified personnel. Occupational and recreational activities not only help structure the patient's day, but offer creative programs in which patients participate according to their emotional health and native capacity.

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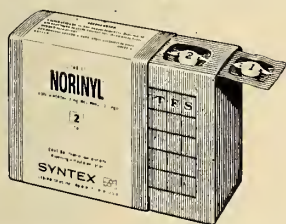
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firm the findings of the Ad Hoc Advisory Committee appointed by the Food and Drug Administration to review this possibility. Cardiac, renal or hepatic dysfunction. Carcinoma of the breast or genital tract. Patients with a history of psychic depression should be carefully studied and the drug discontinued if depression recurs to marked degree. Patients with a history of cerebral vascular accident.

Warning: Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

Precautions: By May 1963, experience with norethindrone 2 mg.—mestranol 0.1 mg. had extended over 24 months. Through miscalculation, omission or error in taking the recommended dosage of Norinyl, pregnancy may result. If regular menses fail to appear and treatment schedule has not been adhered to, or if patient misses two menstrual periods, possibility of pregnancy should be resolved before resuming Norinyl. If pregnancy is established, Norinyl should be discontinued during period of gestation since virilization of the female fetus has been reported with oral use of progestational agents or estrogen. When lactation is desired, withhold Norinyl until nursing needs are established. Existing uterine fibroids may increase in size. In metabolic or endocrine disorders, careful clinical preevaluation is indicated. A few patients without evidence of hyperthyroidism had elevated serum protein-bound iodine levels, which in the light of present knowledge, does not necessarily imply hyperthyroidism. Protein-bound iodine increased following estrogen administration. Bromsulphalein retention has occurred in up to 25% of patients without evidence of hepatic dysfunction. Studies from 24-hour urine collections have shown an increase in aldosterone and 17-

ketosteroids and decrease in 17-hydroxycorticoid levels. Thus, Norinyl should be discontinued prior to and during thyroid, liver or adrenal function tests. Because progestational agents may cause fluid retention, conditions such as epilepsy, migraine and asthma require careful observation. Thus far no deleterious effect on pituitary, ovarian or adrenal function has been noted; however, long-range possible effect on these and other organs must await more prolonged observation. Norinyl should be used with caution in patients with bone, renal or any disease involving calcium or phosphorus metabolism. **Side Effects:** Intermenstrual bleeding; amenorrhea; symptoms resembling early pregnancy, such as nausea, breast engorgement or enlargement, chloasma and minor degree of fluid retention (if these should occur and patient has not strictly adhered to medication plan, she should be tested for pregnancy); weight gain; subjective complaints such as headache, dizziness, nervousness, irritability; in a few patients libido was increased. In a total of 3,090 patients, 2.2% discontinued medication because of nausea.

NOTE: See sections on contraindications and precautions for possible side effects on other organ systems.

Dosage and Administration: One Norinyl tablet orally for 20 days, commencing on day 5 through and including day 24 of the menstrual cycle. (Day 1 is the first day of menstrual bleeding.)

Availability: Dispensers of 20 and 60 tablets; bottles of 100.

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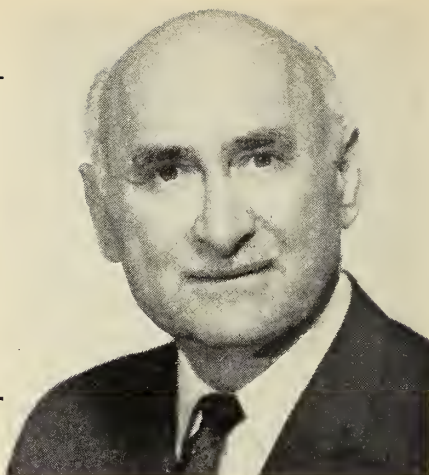
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The president's page



Caesar Portes, M.D.

What We Must Do in 1967

I would like to take this opportunity to wish all the members of the Illinois State Medical Society and their families a healthy and a happy New Year. I also would like to take this opportunity to thank all of the members of the Society, especially the members of the Board of Trustees and the committee chairmen and their members and the office force for their cooperation and help in 1966. I am sure that this same spirit of cooperation and assistance will continue in the coming year.

We have had a difficult time in the past year. The year of 1966 ushered in a big problem for the medical profession entitled Medicare. While it is true that at first we objected to this new legislation and that we offered our own solution to the problem of the aged who are unable to pay for their medical care, none the less, this has been passed as a law by the administration and Medicare is here with its many problems.

As I have said in the past, I will repeat again, that as long as it is a law, we as law-abiding citizens will adhere to the law and try not to undermine it or sabotage it. However, we just cannot sit back idly. We cannot sit back and not to register complaints. We cannot sit back and not try to do something to correct it, to improve it. This has to be part of our effort in behalf of the people in the United States. This we must continue in 1967 or for as long as is necessary to modify, to correct the discrepancies, the irregularities and the difficulties.

I have also spoken in the past about the

image of the doctor. A great deal has been done to improve this image. We hope to continue this in 1967 and forever and ever because the image of the doctor should be the image of a person who is dedicated, who is giving of himself, of his life, his time and his effort in fighting the ills, the diseases of the people of this country.

The new year is going to usher in the legislative session in Springfield. We must become oriented and politically minded to the necessity of taking part in the legislation which has to do with health and the welfare of the people of our state, of our country. We must become more active in our political parties. It need not be necessarily a unilateral action but rather bipartisan action. We must try to contact our representatives, and senators and tell them how we feel about certain amendments, modification or even repeal.

The American Medical Association, the Illinois State Medical Society and your local county societies are making this effort. Through their lobbies they are trying to watch, as you might say, over the legislatures in the state and in Washington, to make sure that your representatives, whom you have elected, will represent you. That they are the ones who will bring to the attention of your legislators the discrepancies, the failings of some of the proposed legislation. This we must continue in 1967. This we shall continue for as long as there is organized medicine. We all belong to organized medicine. We are part of it. With-

(Continued on page 218)

Abstracts of Board Actions

MEETINGS OF JANUARY 14-15, 1967

DR. LULL APPOINTED INTERIM EXECUTIVE ADMINISTRATOR

The Board of Trustees of the Illinois State Medical Society has approved a recommendation that Dr. George F. Lull, past president of the society, assume the position of ISMS executive administrator for the next 12 to 18 months. He will replace Robert L. Richards, who has resigned, effective Feb. 10, to become president of the National Confectioners Association. Dr. Lull has been asked to obtain applications, interview individuals, and prepare dossiers in order that the Ad Hoc Committee may secure services of a permanent executive administrator to succeed him.

SPECIAL REFERENCE COMMITTEE TO STUDY OPINION SURVEY

The Opinion Research Survey, completed last year and assigned to a task force, will be considered by a special reference committee of the 1967 House of Delegates. All delegates and county society officers will receive a copy of the survey in time to review it before the annual meeting. Dr. Edward W. Cannady, Speaker of the House of Delegates, said the reference committee to which this report is assigned will consider no other business during the convention.

Thus, the working reference committees of the 1967 House of Delegates will be:

1. Constitution and Bylaws; 2. Administrative Reports of Officers; 3. Budget and Finance; 4. Insurance and Economics; 5. Legislation and Public Affairs; 6. Publications and Scientific Services; 7. Public Relations and Miscellaneous Business, and 8. Opinion Research Survey.

TWO COMMITTEES ELIMINATED

The Finance Committee report approved by the Board of Trustees shows two committees discontinued:

The Liaison Committee with Blue Cross-Blue Shield has been eliminated because its duties will be assumed by the Committee on Prepayment Plans and Organizations, and the duties of the Liaison Committee with the Pharmaceutical Association have been transferred to the Illinois Association of the Professions Committee, which will be called "Liaison Committee to Other Professional Organizations."

UTILIZATION COMMITTEES FOR ECF

The Board of Trustees has ruled that while physicians should not accept payment for serving on hospital committees (including utilization review committees under Medicare), it is ethical for them to be paid for such service in extended care facilities. County committees on aging may serve as utilization review committees for such facilities in their communities while county committees on prepayment plans act as referral agents in disputes.

LEGISLATIVE DINNERS

The Legislative Committee plans to sponsor dinner meetings in various parts of the state to give physicians and their wives an opportunity to become personally acquainted with their legislators. These meetings will replace the traditional single large dinner given in Springfield in previous years.

POSTGRADUATE EDUCATION

Merck Sharp and Dohme has presented the Illinois State Medical Society with another check for \$5,000 to support the ISMS postgraduate education program. Presentation was made at the board meeting by J. F. Head, north central regional manager for Merck.

LEGISLATIVE ACTIVITIES

The Legislative Committee has informed the Board of Trustees that the following bills will be sponsored and/or supported by ISMS this year in the General Assembly:

1. Medical Review Board for driver licensing; 2. Alcohol content and implied consent to alcohol testing; 3. LSD-DMT control; 4. Amendments to the Medical Practice Act—legal immunity for physicians serving on utilization committees, restoration of citizenship provisions in the act, coordination of the Mental Health Code and Medical Practice Act to permit suspension of license to practice medicine upon committal to mental hospital, enforcement procedures requiring action upon verified complaints and permitting individual to initiate enforcement proceedings under law, prohibition against corporate practice of medicine, (except by medical corporations) and prohibiting solicitation of patients by advertising; 5. restriction on use of hypnosis to medical doctors, dentists and Ph.D. psychologists (licensed); 6. legislation to control the intra-state manufacture and distribution of flammable fabrics.

The Board approved plans for the committee to support these additional legislative proposals:

1. A measure to require immunization prior to admission into public schools as proposed by the Illinois Council on Mentally Retarded and supported by the ISMS Child Health Committee.

2. Restaurant licensing, which would require licensure under established minimum standards for all new facilities in 1968.

3. \$2,000,000 for renal dialysis centers.

4. Operation of clinical laboratories only by physicians licensed to practice medicine in all of its branches.

5. A \$2,359,200 rehabilitation program sponsored by the Narcotics Advisory Council.

6. An adequately staffed professional licensing division for the Illinois Department of Registration and Education.

SEE THE YELLOW PAGES

Pamphlets prepared by the Illinois Bell Telephone Co. to show physicians available listings for the yellow pages of telephone books will be sent to county societies which have jurisdiction over the ethics of such matters.

PILOT STUDY OF PERINATAL MORTALITY DISCONTINUED

The Committee on Perinatal Mortality, which has been conducting a pilot study in 11 counties during the past three years has received permission from the Board of Trustees to end its deliberations. The committee informed the board that it had reviewed almost 900 protocols and believes that patterns of causes and preventability of perinatal deaths have been established in the pilot area. The board approved in principle the request to draw up a plan for a statewide perinatal study.

PRENATAL DETERMINATION OF SEX DISCOURAGED

The Committee on Child Health has recommended that amniocentesis should not be used for the sole purpose of determining the sex of an unborn child, and the Board of Trustees has directed the public relations staff to prepare news releases explaining reasons for this stand.

AMPUTEES IN ATHLETICS

The Committee on Child Health has recommended and the Board of Trustees approved a flexible position regarding below-the-knee amputees participating in contact sports. It is recommended that each case be studied individually by the physician, the parents and coaches before eligibility is decided.



***Dr. Lull Appointed
to Succeed
Bob Richards***

George F. Lull, M.D., president of the Illinois State Medical Society in 1963, has been appointed its executive administrator to replace Robert L. Richards, who has resigned to accept a position with the National Confectioners Association.

Dr. Lull will serve as head of the ISMS staff for a period of 12 to 18 months, during which time he will accept applications, interview individuals, and prepare dossiers on candidates for an ad hoc committee to consider in securing a permanent executive administrator.

A graduate of the Jefferson Medical College in Philadelphia, Dr. Lull also has earned and honorary degrees in public health, law and science from Harvard, Pennsylvania, and the Woman's Medical College of Pennsylvania. He is a fellow of the American College of Physicians and the

American College Surgeons, and he is an honorary fellow of the International College of Surgeons and of the American College of Chest Physicians.

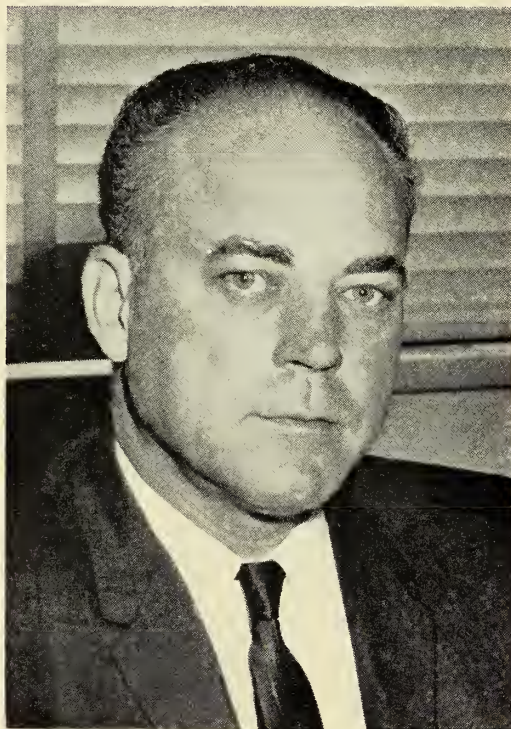
For 33 years he was a member of the U.S. Army Medical Corps, attaining the rank of major general. During the last two years before his army retirement, he served as deputy surgeon general of the United States. He wears the Distinguished Service Medal, the Purple Heart, the French Legion of Honor Medal, and Cuba's Carlos Finlay Order of Merit.

From 1946 to 1959 he was secretary and general manager of the American Medical Association. In 1960 he became secretary-treasurer of the Illinois State Medical Society and later served as its president. Recently he has been medical director of the Cook County Public Aid Department.

Public Aid's New Physician Reim

Illinois to Pay Doctors' Usual and Customary Fees

By MARVIN SCHRODER
Illinois State Medical Society
Division of Public Relations and Economics



Harold O. Swank

A new program of reimbursement to physicians who treat public aid patients has been initiated by the Illinois Department of Public Aid. The program was agreed upon as a result of lengthy and exhaustive discussions between the ISMS Committee on Usual and Customary Fees and Harold O. Swank, Director of the Department of Public Aid.

The agreement is retroactive to all medical procedures rendered on or after Jan. 1, 1967. Its continuation is subject to review by the ISMS House of Delegates and the Department of Public Aid following six months experience.

In this interview, Mr. Swank discusses the import of the new program and provides answers to questions on the mechanics of the new payment program.

The Illinois Department of Public Aid administers funds for all public assistance programs financed by federal, state and local funds.

At the end of October, 1966—the latest date for which statistics are available—there were 408,360 persons receiving assistance from the Department of Public Aid. That is approximately four percent of the entire Illinois population.

Of the total, 356,794 persons were eligible for assistance under programs supported in part by federal funds. These programs, and the number of persons receiving aid under each, are:

Old Age assistance—58,746

Aid to Dependent Children—261,869

Aid to the Blind—2,230

Disability Assistance—33,949

In addition, there were 51,566 persons receiving general assistance.

What is your department's new policy on paying physicians who treat public aid patients?

We will pay—in most instances—the usual, customary and reasonable charges of physicians for various services provided. We recognize that usual and customary charges vary from physician to physician and from county to county.

(Continued on page 226)

ement Program . . . How It Works

Thomsen Warns Against Increasing Normal Charges

By PHILIP THOMSEN, M.D.

*Chairman, Committee on Usual and Customary Fees
as told to the Division of Public Relations and Economics*

The new program under which the Illinois Department of Public Aid will pay the usual, customary and reasonable fees of most physicians who treat public aid patients is an excellent illustration of what can be accomplished when men of good faith engage in full and frank discussions to achieve a mutual goal.

The ISMS Committee on Usual and Customary Fees has, over the past several months, held many meetings with Harold Swank, Director of the Department of Public Aid, in an effort to arrive at an agreement that is fair to both physicians and the Public Aid Department.

The committee recognizes that the new program falls short of being perfect—that there are inequities in it. You can be assured, however, that the committee will make continuing efforts to correct these inequities.

New Program Superior

At the same time, the committee is also aware that the new program is vastly superior to the one which it replaced. For the first time, physicians will be paid a realistic fee.

In terms of dollars, payments to physicians for medical services to public aid patients will increase from \$7.5 million a year to \$15.5 million a year.

The program will be reviewed after six months by both the ISMS House of Delegates and the Public Aid Department. It is, in effect, on trial—and its future will be largely decided by the doctors of Illinois.

Some months ago, ISMS asked its members to cooperate in a survey to determine the range of 1966 usual and customary fees charged for various medical procedures.



Philip Thomsen, M.D.

Your cooperation then was gratifying—more than 60 percent of the questionnaires were completed and returned. Because of your cooperation, ISMS was able to show that payment of usual, customary and reasonable fees would not result in astronomical costs to the Public Aid Department. From that point, we were able to move into this new program.

Now, ISMS again calls upon you for your cooperation. It is absolutely essential to the program's success that doctors bill the

(Continued on page 222)



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**SURGICAL
GRAND
ROUNDS**

Case Presentation:

Glossopharyngeal Neuralgia

Northwestern University Medical Center *Surgical Grand Rounds are held weekly at 8 a.m., alternating between The Staff Room, Chicago Wesley Memorial Hospital and Official Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of Surgical Grand Rounds held at Chicago Wesley Memorial Hospital on May 21, 1966.*

EDITED BY JOHN M. BEAL, M.D.

Dr. Richard Jelsma: A 54-year-old woman was in good health until 11 years before admission. At that time she had carcinoma of the right breast, treated by radical mastectomy and x-ray therapy to the axilla and chest. Three years before admission she developed an unsteady gait, associated with episodes of nausea, vomiting and vertigo. These symptoms gradually disappeared although the unsteady gait persisted.

In 1964 several cutaneous nodules were noted on the chest and on the left side of the face and head. These were treated with six local treatments of x-ray therapy at each nodule and the nodules disappeared. Nine months before admission episodes of sharp shooting pain in the left temporo mandibular joint to behind the left ear occurred. This pain was increased by swallowing and by eating and occurred in episodes lasting 10 to 30 minutes.

Six months before admission the pain affected the left side of the throat as well and was noted to be much worse when she ate pickles or sour food.

Four months before admission left facial weakness was noted to be associated with the pain. Her private physician made a diagnosis of trigeminal neuralgia and treated her with Dilantin without effect. Later he injected the third division of the trigeminal nerve with alcohol with resultant numbness on the left side of the face. However, pain continued in the throat although the facial pain improved.

She was admitted to Wesley following a severe attack of throat pain. When examined, she had weakness of her seventh, ninth, tenth, and eleventh nerves as well as a fifth nerve deficit. Peripheral lymph nodes were not palpated nor were there cutaneous nodules noted. Hemogram and urinalysis were normal. These findings suggested a posterior fossa tumor, most likely metastatic from carcinoma of the breast. Chest films were negative. Liver function, including serum alkaline phosphatase test, were normal.

Dr. Abram Cannon: Routine skull films appear to show rarefaction at the left petrous tip. The right side is normal. Laminograms of the petrous apices were not helpful. A left brachial angiogram outlined the vertebral basilar system very well. The lateral view demonstrated that the posterior cerebral arteries were at a different level on each side. The left posterior cerebral artery appeared to be stretched over a mass (Fig. 1). These findings indicated a tumor near the tip of the petrous bone.

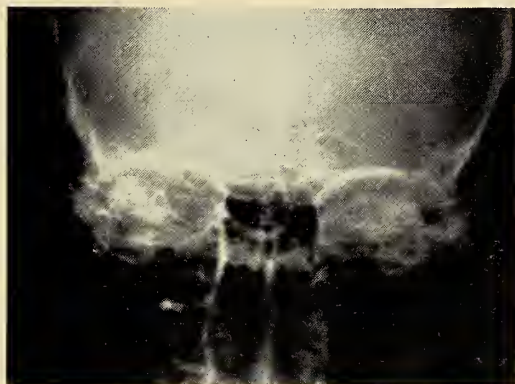


Fig. 1. Left brachial angiogram demonstrated an apparent distortion of left posterior cerebral artery.

Dr. Jelsma: A left suboccipital craniotomy was performed. The posterior fossa was exposed. The ninth and the upper part of the tenth nerves were sectioned. Postoperatively the patient has had no throat pain and has

made an uneventful recovery. Because of the neurologic deficits it is assumed that the patient has metastatic tumor in the base of the skull and she is being treated with x-ray therapy.

Patient is Presented

Dr. Jelsma: She still has some facial weakness but her symptoms have dramatically improved. Have you had any pain in your throat since operation?

Patient: I don't have pain any more.

Dr. Jelsma: Do you have any trouble in swallowing or in drinking liquids such as milk or water?

Patient: No.

Dr. Edir Siqueira: There are many definitions for neuralgia. This may be confusing at times. Let us use this word to indicate severe paroxysmal attacks of pain around the distribution of a certain nerve. Neuralgia can be secondary or primary. Primary neuralgia is of unknown etiology. The pain is present without demonstrable cause. Secondary neuralgia is most commonly caused by tumor. In this particular case the patient had a secondary type of neuralgia although the tumor has not been demonstrated. The tumor is presumed to be in the petrous pyramid because of the patient's neurological findings. Neuralgia about the face has several causes. The most common cause is trigeminal neuralgia, the familiar "tic douloureux." Glossopharyngeal neuralgia is the second most common cause although much less frequent. We encounter perhaps three or four cases of glossopharyngeal neuralgia for every 100 cases of trigeminal. Neuralgia of the seventh nerve is rare indeed.

A patient with glossopharyngeal neuralgia has the pain along the distribution of the ninth nerve. The pain is mainly in the tonsillar region and in the external auditory meatus; which are important points in differentiating from trigeminal neuralgia. The diagnosis in glossopharyngeal neuralgia usually is not difficult when one is familiar with the entity. The history is quite typical: severe bouts of acute excruciating pain, usually while swallowing or talking. Trigeminal neuralgia may occur also with eating but the pain occurs when the food or the liquid is still in the mouth. In glossopharyngeal neuralgia the pain may be so

severe as to cause a momentary syncope. This syncope is explained by the fact that the glossopharyngeal nerve has strong connections with the tenth nerve which is one of the regulators of the cardiac rate. Application of topical anesthetic to the tonsillar fossa should relieve the pain; a major differential point. In the differential diagnosis one should consider, among other entities: 1) Vasomotor facial neuralgia—the episodes of pain are not acute; 2) Nasopharyngeal tumors—usually cause continuous pain in the region.

The operative procedure for relief of glossopharyngeal neuralgia is a very satisfactory one. The incision is made just behind the ear to expose the occipital bone. A small craniectomy is done and the cerebellum is exposed. The cerebellum is retracted, exposing the nerves of the base of the brain. The ninth nerve is easily identified and sectioned. The tenth nerve may be responsible for some of the pain in cases of glossopharyngeal neuralgia, and for this reason some of its upper rootlets are cut. This does not impair the function of this nerve. The results are gratifying. Although the patient does develop some numbness of the ipsilateral side of the throat including the tonsillar fossa, actually the patient usually is not aware of this. They do not have trouble swallowing.

Dr. John Beal: This patient's prognosis now depends on her basic disease. Dr. Wetzel, is this problem ever bilateral?

Dr. Nicholas Wetzel: Yes, it can be bilateral but is certainly rare. I question whether this patient should be considered as having glossopharyngeal neuralgia in its usual sense and instead pain in the head and neck due to metastatic disease. It is very important in the treatment of the patients with head and neck pain that a very definite diagnosis be made because of the difficulties that arise if surgical therapy is carried out for the wrong diagnosis. For patients with pain from metastatic disease, a rather extensive procedure often needs to be done. Sectioning a few cranial nerves is not enough because of the considerable overlap. Deep pain in the face may be due to involvement of the nervus intermedius. This nerve lies between the acoustic nerve and the facial

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Needless Blindness from Senile Cataracts

JOHN G. BELLOW, M.D. Ph.D./CHICAGO

The major cause of blindness in adults particularly those over 65 years of age is cataract. There is now no reason for any individual in this country to suffer blindness from cataract, because with the advent of Medicare the financial reasons for delaying cataract extraction have been removed. Because of the recent advances in the surgical procedures, there are no mental or physical disorders that preclude a successful restoration of vision.

Unfortunately, many physicians still consider cataract surgery to be a major risk to the life of the aged and the infirm. Nothing could be further from the truth. With proper management, the possibility of serious complications or death from cataract surgery is virtually non-existent. The discomfort is minimal, and may be easily controlled by analgesics. The patient is ambulatory as soon as the effects of the sedation abate.

No person should be visually handicapped by uncomplicated cataract because he has high blood pressure, diabetes or heart disease. These conditions are not worsened by modern cataract surgery, nor do they influence the outcome of the procedure. Indeed, the only consideration should be an evaluation of the patient's life expectancy. If a modicum of vision is adequate for the patient's remaining days, cataract surgery is not indicated. On the other hand, the restoration of vision in a blind patient with a short life expectancy may be justified, for it is evident that the return of sight would add to his enjoyment in the remaining months. In some instances, the visual restoration may be instrumental in prolonging his life, because of the in-

creased mobility and participation in daily activity. This adds to the period of his useful life and increases the will to live. Inactivity and isolation caused by blindness is far more damaging to the patient's physical and mental well-being than surgery would be.

Part of the responsibility for the current misconceptions has been the poor communication between the general practitioner and the ophthalmologist. The recent advances have been reported in the specialty journals, but little has reached the more widely circulated journals. If cataracts were not such a widespread and increasing problem, this lack of communication might not be too serious. However, since some form of cataract is observed in 90 percent of all persons over 65, the number of individuals who are concerned with this problem has grown from 3,500,000 to more than 18,000,000 within the last 50 years.¹ This does not mean that all of these persons will require surgery, because some cataracts progress slowly or not at all, and in many instances, death ensues before the patient is visually disabled. Recent advances in cataract surgery have been eminently successful in restoring sight to even the most debilitated, with slight inconvenience and practically no danger to the patient. These major advances have been in anesthesia, analgesia, antibacterial agents, suturing materials, zonulolysis, and cryoextraction.

Anesthesia and Wound Closure

Anesthesia may be either general or local, depending largely on the availability of an experienced anesthesiologist. The patient lies comfortably on a well-padded table, with a soft doughnut-shaped pillow under his head. When using local anesthesia, a combination of analgesics, sedatives and

Dr. Bellows is a practicing ophthalmologist and associate professor at Northwestern University Medical School, Chicago.

antinauseants are used to produce calmness, tranquility and sedation, ending in amnesia and euphoria. It is no longer necessary to ask the patient to look up and down; the surgeon retains control of the situation by using bridle sutures that enable him to turn the eye in the desired position. Although he is fully conscious and responsive during the operation, the patient feels no discomfort.

Novocaine or xylocain in 2 percent solution is injected in the retrobulbar region and along the course of the facial nerve fibers leading to the orbicularis muscle. These measures not only eliminate pain and discomfort, but make it virtually impossible for the patient to move his eye or to squeeze his lids.²

Furthermore, the elimination of post-operative nausea and restlessness along with the improvements made in wound closure has greatly reduced the incidence of post-operative hemorrhage, wound rupture, loss of vitreous and iris prolapse, which formerly plagued the ophthalmologist.

Advances in wound closure have abolished the need for prolonged bed rest and immobilization of the head. The patient sits up in a wheel chair immediately upon his recovery from the effects of the sedatives and, as soon as he is capable he becomes ambulatory. Within a few hours he resumes most of his normal activities, including bathroom privileges.

Antibacterial Agents

The use of antibiotic agents does not replace the need for the aseptic technics that have guided ophthalmic surgeons for so many years. Obviously, a patient showing signs of infection of the lid, conjunctiva or lacrimal sac should not be subjected to surgery until the infection is cleared. Smears and cultures should be negative. Antibacterial agents that may cause hypersensitization (e.g. penicillin) should never be used for this purpose, because it may be necessary to use them later on as a life-saving measure.

Many ophthalmologists routinely recommend a local non-sensitizing antibacterial agent, such as chloramphenicol: (1) instilling drops several days before the operation, even in the non-infected eye, as a further safeguard against infection; (2) flushing

out the conjunctival sac immediately before and after surgery, or injecting it subconjunctivally; (3) and during the post-operative course applying the antibacterial agent in the form of an ointment or solution with the daily change of dressing.

Zonulolysis

The use of the enzyme, alpha chymotrypsin, for the disintegration of the zonules (the suspensory ligament of the lens) has enabled the surgeon to safely remove cataracts intracapsularly in younger patients than was formerly possible. However, while enzymatic zonulolysis was enthusiastically and rapidly adopted by ophthalmologists throughout the world, recent reports of undesirable effects have caused some surgeons to re-examine their operative results and to discard the procedure. The reported untoward effects are attributed to poor wound healing, with resulting flattened anterior chamber due to a delay in reformation of the anterior chamber and glaucoma.³ Another adverse effect is the spontaneous opening of the wound, causing prolapse of the iris and vitreous. Fortunately with the adoption of the new method of cryoextraction, enzymatic zonulolysis is rarely indicated in the removal of senile cataracts.

Cryoextraction

The most outstanding ophthalmological advance in recent years is the application of low-temperature technics to the removal of cataracts.

The underlying principle of cryoextraction stems from the common observation that when a cold metal tip at a temperature between -10° C. and -80° C. comes in contact with a moist object, ice particles form to fuse them.

In cataract extraction the tip of the cryogenic instrument is applied to the moist surface of the lens, producing an ice mass within the lens which is virtually an extension of the extractor. Thus, when the tip of the instrument is withdrawn from the eye, the cataract which is fused to it is removed at the same time. The firm adherence of the cataract to the instrument permits the cryosurgeon to remove the cataract by torsion and traction and eliminates the use of pressure upon the globe. On the other hand with the older method the sur-

geon using either forceps or the erisophake was able to secure only a flimsy grasp of the delicate lens capsule. Since the fragile capsule was readily broken with only a small amount of traction, the surgeon had to rely mainly upon pressure on the globe to break the zonular attachments and thereby free the cataract. The superiority of torsion and traction maneuver with the cryo-extractor to rupture the zonular attachments and to free the cataract prior to its removal over that of pressure and stretching used in older methods, is demonstrated in plucking an apple from a tree; much less effort is required to free the fruit by twisting it off the stem (torsion and traction), than is needed by stretching and pulling it off.⁴

As shown in the foregoing, cryoextraction of a cataract is safer and simpler than extraction with forceps and the erisophake and as a result the successful outcome of cataract surgery has been improved percentagewise. The poorer results obtained with the older method were due to the more frequent capsular breakage and the retention of lenticular material resulting in intraocular infection because lens remnants make an excellent culture medium,

phacogenic hypersensitization reactions and glaucoma, and the formation of a secondary cataract. These complications may nullify the effects of the operation.

Conclusions

The adoption of cryosurgical technics, improvements in wound closure, and in anesthesiology along with Medicare have removed most of the reasons for delaying surgery and have made it possible to eliminate senile cataract as a cause of blindness. Even the very old and the infirm with diabetes mellitus, cardiovascular diseases, senile mental diseases and other chronic disorders may now be subjected to modern cataract surgery with practically no mortality from this procedure. The discomfort is minimal and there is little strain on the patient's physical resources. The joy that follows the restoration of sight more than compensates for the minor inconveniences resulting from the operation. The tonic-like effects of seeing again increase the patient's will to live and increase his mental and physical activities. Mental confusion is frequently ameliorated. Other than terminal cases, there are no reasons for patients to remain blind because of senile cataracts.

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A limited supply of "Medicare and the Physician," the American Medical Association's 96-page reference guide of questions and answers dealing with Public Law 89-97, is still available. If you failed to receive your copy or need an additional one, you may obtain one by writing the Program Services Department, American Medical Association, 535 N. Dearborn St., Chicago 60610. The publication which, among other things, explains provisions of the law, its limitations and procedures to be followed in a wide variety of instances, was prepared as a professional service for members of the AMA.

Fiedler's Myocarditis and Heart Block with Scar Tissue Injury of Septal Nerves

EDWIN F. HIRSCH, M.D., VALLEE L. WILLMAN, M.D.,
GEORGE C. KAISER, M.D., AND THEODORE COOPER, M.D., Ph.D.

Glomset and Birge (1948)⁶ assembled the published reports on the pathogenesis of heart block and of bundle branch block recorded for 76 patients with this disorder. They supplemented this review with the results of their own studies of the hearts from 28 patients with disturbances in cardiac conduction. The myocardium in 90 percent of the 104 hearts had fibrous scars in the upper portion of the interventricular septum. Scars in these septal tissues were present in 70 to 80 percent of patients with various forms of bundle branch block. Glomset and Birge, in agreement with many others, considered the septal scars responsible for the cardiac disorder. Any one of several diseases, they stated, may produce morbid changes in the septum, which ultimately became a scar. Many of these scars in human hearts result from infarction; some are caused by chronic forms of myocarditis, focal and systemic granulomatous diseases, or other disorders.

Injury of Nerve Tissue

The causal relationship between the scar tissue replacement of these septal myocardial tissues and heart block, for many years, has been ascribed to an imputed interruption of the conductive tissues that are distributed in this region of the heart.

From the Henry Baird Favill Laboratory of Presbyterian-St. Luke's Hospital, and the Pathology Laboratory of Columbus Hospital, Chicago; and the Department of Surgery and the Center of Cardiovascular Research of St. Louis University, St. Louis, Mo. Aided by funds given by Mrs. Richard W. Leach, by the Seymour Coman Fund of the Department of Pathology of the University of Chicago, and by grants from the John A. Hartford Foundation and the USPHS (HE - 06312).

Glomset and Birge, however, proposed that the real cause of heart block does not concern these conductive tissues, but rather is an interruption by injury of nerve tissue functions in this portion of the septum. They did not record details of septal innervation, nor did they describe injuries of septal nerve tissues to support their views. In rationalizing a neural as opposed to a myogenic cause of heart block, they argued against a functional purpose of the conductive system in total cardiac function. Their contention, of course, conflicted with the theory widely accepted for many years that the conductive tissues are the pathway for the transmission of impulses which influence the rhythmic contractions of the heart. Other investigators of cardiac physiology have expressed similar skepticisms about the functional role of the conductive system.

Nerve Fibers in Myocardium

Glomset and Cross (1952)⁷ in a later report emphasized the presence of nerve trunks and of ganglia in the epicardial tissues at the base of the heart. In optimum histological preparations stained by the Bodian method, they observed "with amazement" an abundance of nerve fibers in the myocardium and were inclined to agree with Smirnow²⁵ who years ago had expressed the opinion that every muscle cell (band) in the heart is supplied by motor nerve endings.⁸⁻¹⁵

Rossi²¹ in 1955 again collated the contributions offered by the opponents of the neural and of the myocardial theories on the transmission of stimuli which influence the rhythmic contractions of the heart. He recorded studies of four hearts from pa-

tients with conduction block. These had marked changes of the nerve tissues in the septums; the His-Tawara system in two hearts had no abnormalities. Rossi reported that the cardiac septum in the region of the fibrous body has nerve elements in abundance, within and in close proximity to the His-Tawara system. He observed evidence of widespread distribution of nerve terminal arborizations in cardiac muscle. These nerve tissue pathways, he continued, have been disregarded in most of the reports concerned with anomalous cardiac rhythms. Rossi's report included an extensive list of bibliographic references on heart block.

Ganglia Associated with Nerves

The first publication¹⁶ in our studies of heart block described the distribution of nerves in the septum of the canine and the human hearts. The ordinary septal cardiac tissues and the specialized myocardium of the conductive system, as therein recorded, have a rich supply of large and small nerves containing myelinated and nonmyelinated fibers, fascicles of fibers bonded with collagen, and fibrils. Numerous large and small ganglia are associated with these septal nerves. According to current concepts, the distribution of ganglia in the vagal and the sympathetic components of the autonomic nerves to the heart is not the same. The ganglia of the sympathetic component are in longitudinal chains on each side of the spine; those of the vagus are distributed near or in the heart. Accordingly, the association of ganglia with, or of ganglion cells in, the epicardial and intracardiac nerves suggests that these nerves are parasympathetic. The third¹⁷ in our series of studies on experimental heart block in the dog records the confirmation of this concept through the technique of bilateral cervical vagotomy, bilateral thoracic sympathectomy and total extrinsic denervation.

Heart, Spine Ganglia

Many ganglia are distributed with epicardial nerves at the base of the heart and with cardiac nerves that enter the interauricular septum in the adventitia of the aorta. These ganglia contribute short postganglionic motor vagal fibers to cardiac tissues. Other long postganglionic motor

fibers reach the heart from the sympathetic ganglia along the spine. A cluster of large nerves associated with many ganglia is distributed regularly in the interauricular myocardial and fat tissues behind and near the lower edge of the pars membranacea in the septum of the dog.

Large nerves associated with ganglia penetrate the interauricular septum of the human heart at the level of the coronary sinus. In the dog, this specific cluster of nerves with ganglia contributes trunks or branches to the ordinary myocardial tissues and to an ovoid mass of myocardial cells nearby which is continuous with the posterior terminus of a large right branch of the bundle. These nerves and their meshes of fibers, fascicles of fibers and fibrils continue forward with the right branch to the bundle. Some nerves have been traced with these specialized muscle tissues through the septum and into the left bundle branch. Other nerves of the cluster mentioned continue into the ventricular myocardium.

Relationship of Nerves, Ganglia

The presence of ganglia associated with nerves establishes specific anatomic characteristics for these septal tissues of the heart. These tissues with nerve-ganglion structures contrast with cardiac tissues in many other regions of the heart where nerve distributions are beyond the level of this nerve-ganglion association. The localized relationship of nerves and ganglia in specific septal tissues of the heart, moreover, may be significant because this is in or near critical tissues where an injury may cause heart block.

The ordinary myocardium of the septum has nerves, an abundance of the perimyocardial plexus fibers and fibrils, and the arborization terminals. The specialized myocardium of the conductive system also has nerves or their branches, sinuous fibers and fascicles of fibers, arborization terminals and some fibrils. The intricately fashioned and abundant nerve-ganglion innervation in the septal tissues, with proper technics and interpretations, could be key tissues whereby some of the challenging functional relationships between nerve and cardiac muscle could be established. These details then enhance the interpretation of nerve-muscle relationships in other cardiac tissues.

Case Report

A 48-year-old white female was admitted to the hospital for episodes of weakness and syncope of two and one-half years duration. The episodes, characterized by blurring of vision, some generalized weakness and slow pulse rate, gradually increased in frequency despite treatment with Isuprel. There was no history suggestive of coronary insufficiency or cardiac decompensation. Three weeks prior to admission one of the episodes was accompanied by loss of consciousness. She previously had an abdominal hysterectomy and an appendectomy.

During physical examination the patient was apprehensive. The radial pulse was 38/min and irregular; the blood pressure was 100/60 mmHg. The heart tones were soft, distant and irregular at 38/min. No murmurs were heard. The nontender liver was palpable just below the right costal margin. The remainder of the physical examination was unremarkable.

Laboratory Data

Laboratory data revealed fasting blood sugar, 99 mg%; BUN, 10 mg%; cholesterol 260 mg%; sodium 145 meq/l.; potassium, 4.0 meq/l.; chloride, 108 meq/l.; CO₂, 26.1, VDRL nonreactive; urinalysis, normal; white count, 3686, differential normal. Hemoglobin 13.2 grams. Hematocrit 40%. SGOT 62.

X-ray of the chest revealed no evidence of disease or of pleural effusion. The cardiac silhouette was enlarged in the transverse diameter. The thoracic aorta was elongated and tortuous. The electrocardiogram on admission revealed an atrial rate of 76, and a ventricular rate of 38 and was interpreted as second degree heart block, with two to one conduction and complete right bundle branch block. On the day following admission the electrocardiogram revealed an atrial rate of 79, a ventricular rate of 44, and was interpreted as complete heart block with idioventricular rhythm and occasional sinus captured beats with normal conduction. During the initial 48 hours of hospitalization, the patient developed several episodes of ventricular tachycardia which terminated spontaneously. Complete atrioventricular block persisted. On the second day after ad-

mission an electrical pacemaker was implanted. At the time of operation the heart was noted to be enlarged but otherwise normal in gross appearance. Due to the preoperative myocardial irritability the patient was placed on quinidine sulfate, 800 mg. a day. Following an uneventful postoperative course the patient was discharged on the 12th postoperative day. The ventricular rate was determined by the electrical pacemaker and was 68/min.

Syncope After Seven Months

The patient seemed well for seven months at which time she again experienced an episode of syncope. No cause for the unconsciousness was found; the pacemaker appeared to be activating the heart adequately. She was placed on dilantin and phenobarbital, in addition to the maintenance quinidine. One month later she was readmitted to the hospital for evaluation. Physical examination at this time revealed blood pressure to be 110/70 mmHg., pulse was 68/min and regular. Electrocardiogram revealed complete atrioventricular block (Fig. 1) with pacing by the artificial pacemaker and good ventricular response. Electroencephalogram was interpreted as demonstrating mild, diffusely abnormal dysrhythmia consistent with a generalized disturbance of cerebral function but no focal abnormality. Other laboratory studies were not remarkable. After four days of hospitalization the patient was discharged.

Atrioventricular Block

A month later the patient experienced a sensation of faintness and weakness. However, she did not lose consciousness. She noted her pulse to be slow but did not determine the rate. On admission to the hospital the pulse rate was 44 and regular. Electrocardiogram revealed complete atrioventricular block, the artificial pacemaker did not regulate the heart rhythm as on prior examinations. Roentgenographic examination of the pacemaker leads failed to demonstrate an interruption in continuity of the wires. Since the implanted system failed to drive the heart, external pacing was initiated. Approximately 12 hours later through a right thoracotomy a new pacemaker was implanted and appeared to function properly. After the thoracotomy

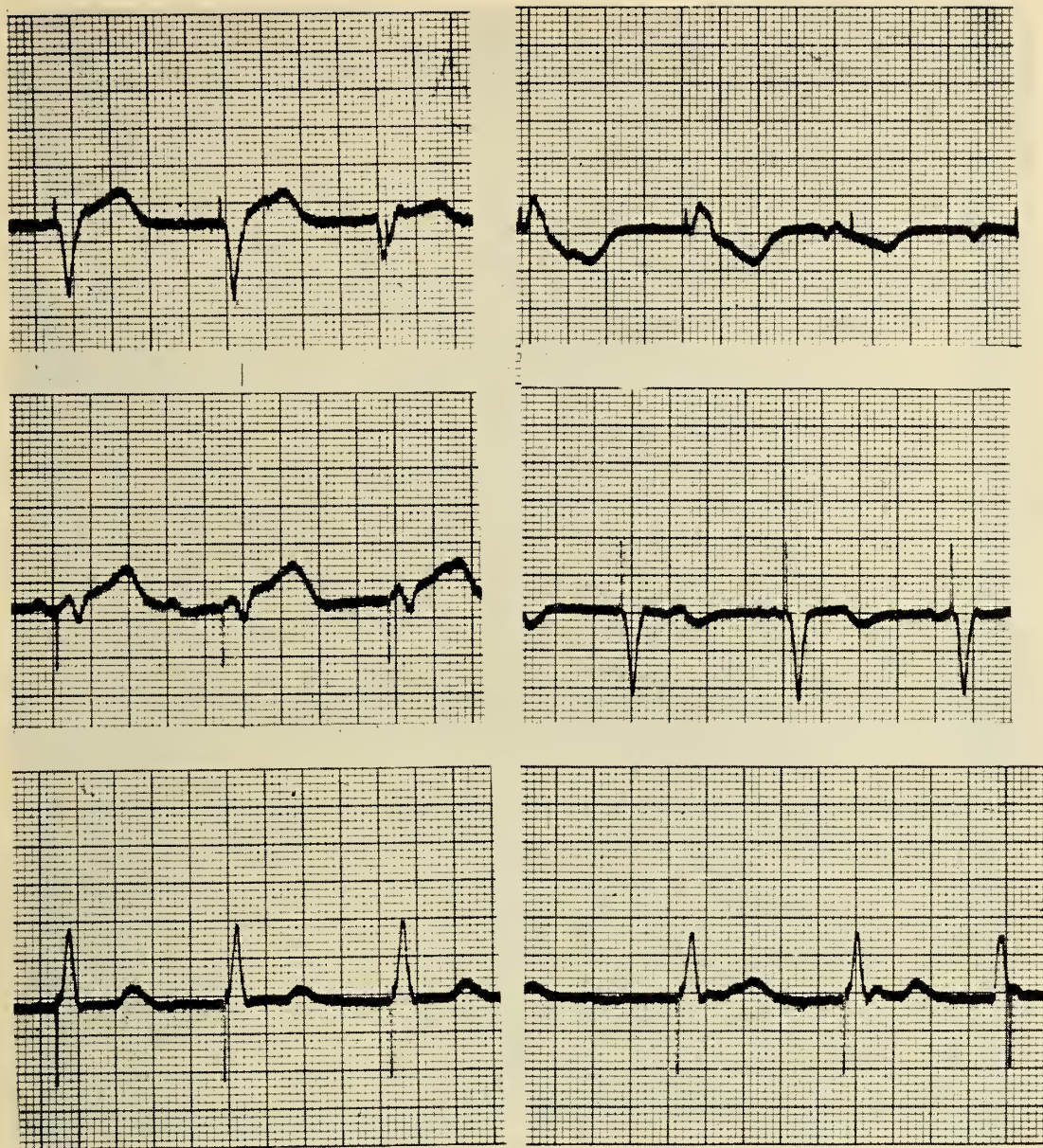


Fig. 1

incision was closed, the old implanted pacemaker was removed from its subcutaneous pocket over the left upper quadrant. During the latter procedure the heart escaped from the stimulus of the newly implanted pacemaker. Episodes of ventricular extrasystoles and ventricular tachycardia occurred. During a five minute period the patient was given a total of 1.2 grams of pronestyl and 320 mg. of quinidine. The arrhythmia persisted and the patient became hypotensive. Intravenous norepinephrine was begun; ventricular

fibrillation supervened. External cardiac massage was begun immediately and defibrillation was accomplished. It was apparent that the heart was not following the internal pacemaker. The leads were exteriorized and the heart was paced at a rate of 100 from an external source. No further episodes of ventricular tachycardia or ventricular fibrillation ensued. The postoperative period was marked by oliguria which was treated by fluid restriction and peritoneal dialysis. In spite of vigorous supportive therapy, the patient died on the

tenth postoperative day. Postmortem examination demonstrated renal tubular necrosis, acute pancreatitis, and the cardiac disorder described in detail below.

Shaggy Epicardial Surface

This large human heart, originally weighing 460 gms. and now fixed in Zenker's solution had a shaggy epicardial surface. Two insulated fine electrode wires were imbedded about 4 cms. apart in the epicardium on the anterior surface toward the apex of the left ventricle. Two other fine bare wires less than 1 mm. in diam. and 1.5 cm. long were embedded about 1 cm. apart on the posterior surface near the apex and the lateral edge of the right ventricle. Another single wire similar in dimensions, was embedded in the epicardium near the septum toward the base on the posterior surface of the right ventricle.

The chambers of the heart were dilated; the linings were smooth. The myocardium

visible through the ventricular endocardium had gray plaques. The lateral wall of the left ventricle was 2 cm. thick. Surfaces made by cutting were fibrillar and firm. The leaflets of all of the valves were thin. The linings of the root and arch of the aorta, of the pulmonary artery and of the coronary arteries was smooth.

Septal Tissues Divided

The block of septal tissues removed for histologic study included the conductive system and other structures. It was divided into two equal blocks, an anterior and a posterior. Each was sectioned serially in the horizontal plane, starting above. The sections mounted on alternate slides were stained according to Gomori's trichrome method; those on the slides between by a Bielschowski silver reduction technic as described by Nasser and Shanklin,²⁰ followed by the Gomori's trichrome.

As the serial sections descended in

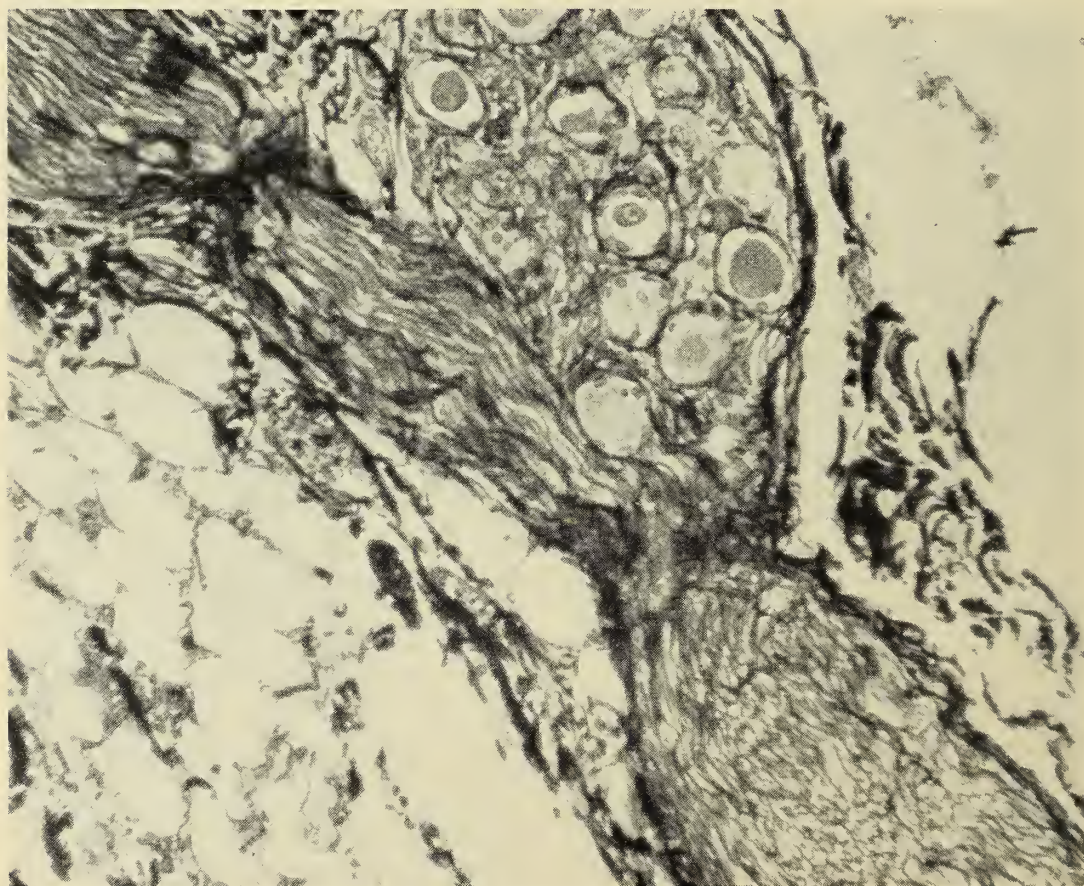


Fig. 2. Photomicrograph illustrating nerves associated with ganglia in the interauricular septum opposite the coronary sinus.

the posterior block, large and small nerves, some with ganglia, appeared in the fat and the muscle tissues of the interauricular septum. Toward the ventricular level, masses of dense hyalin scar (Fig. 3) and lymphocytic granulation tissues (Fig. 4) appeared anteriorly in the sections and increased in amounts in the sections at lower levels. Extensive portions of the ventricular myocardium were replaced by these hyalin scars. Numerous foreign body giant cells, (Fig. 3, 4, 5) ranging in size and contour were distributed in the scar tissues. The initial stages of the granulomas seemed to be mainly lymphocytic (Fig. 4) and as they evolved the hyalin collagen increased, the scars became dense, poorly cellular and confluent. (Fig. 3) There were occasional small groups of granular mononuclear phagocytes but these seemed to be transient elements.

Cells Vary in Size

The giant cells, considered to be foreign body, had many oval vesicular nuclei with

coarse chromatin granules and large amounts of granular cytoplasm. The giant cells ranged greatly in size and shape (Fig. 5). Many, if not all, had clusters of rounded inclusion bodies, faintly stained by the procedures mentioned, 1 to 5 μ in diam. and with a round central body that in the small forms appeared bright red. Some aggregates of these bodies were in stages of inclusion by giant cells. They also were in residues of myocardial bands at the margin of the granulation tissues. The nature of the rounded inclusion bodies in the giant cells was not established by special stains. Healing or scarred infarcts of the human heart do not have foreign body giant cells with similar inclusion bodies. Derivatives of necrotic myocardial tissues seem therefore not to be the substance of the inclusion material.

Dense Scar Tissues

The anterior block of septal tissues was processed as described. Nerves, some with ganglia, were in the adventitial tissues of the aorta; others were in cardiac tissues

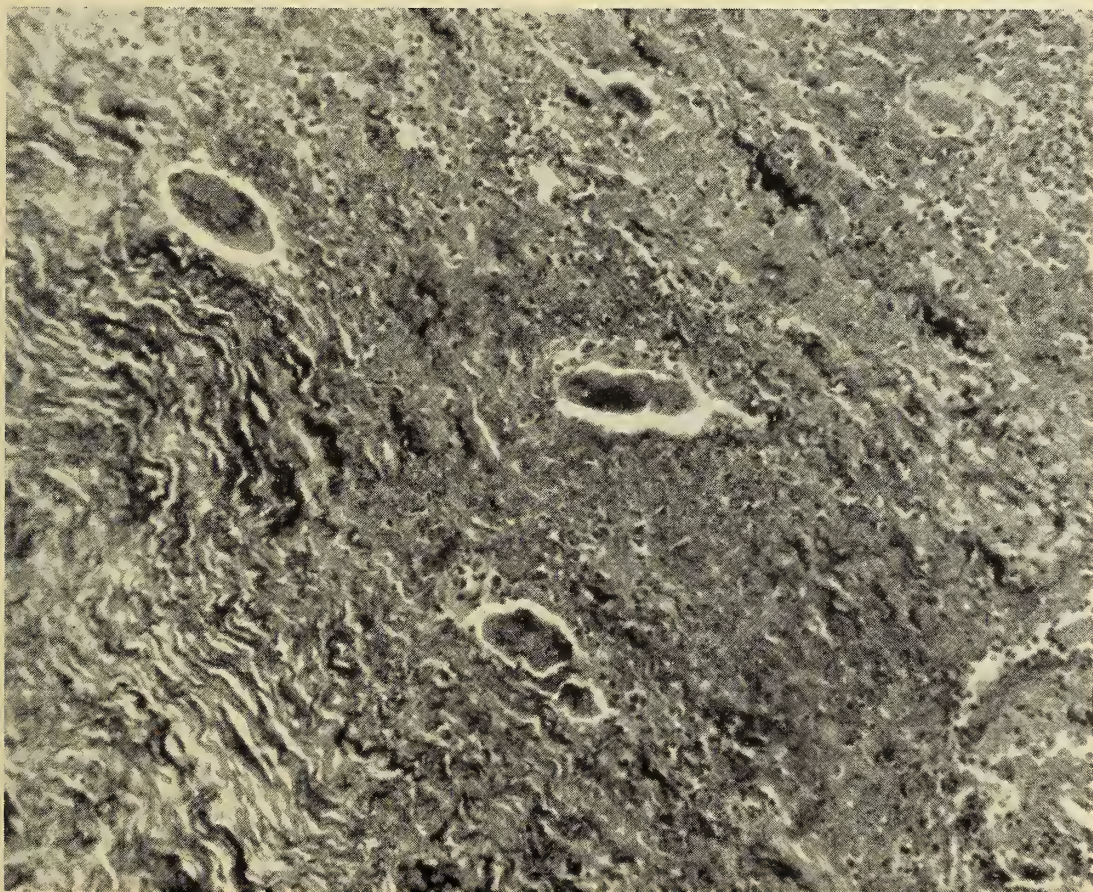


Fig. 3. Photomicrograph (low power) illustrating the dense collagenous fibrous scars with giant cells in the septal tissues.

near the coronary sinus (Fig. 2). The upper portion of the interauricular septum had large amounts of fat. Granulation tissues and dense hyalin scars, as described, appeared in the septal myocardium as the sections descended. Extensive portions of the myocardium were replaced by the dense collagenous scar tissues with the scattered foreign body giant cells, containing the inclusion bodies. Residues of the a.v. node, the bundle and of the main branches of the conductive system remained (Fig. 7A). Nerves, their fascicles and their terminals in the region of the myocardium replaced by the scar tissues were engulfed or destroyed. The collagenous matrix or binder associated with the nerve structures was fused into the hyalin scars. Nerves in phases of regression (Fig. 6) were identified in the scar tissues. Tissues in other portions of the heart also had isolated and confluent regions of granulomatous myocarditis.

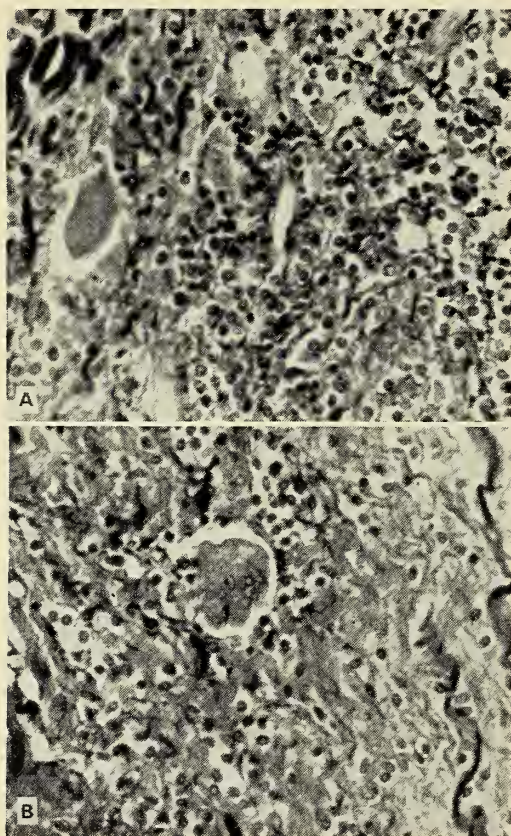


Fig. 4. Photomicrographs (high power) illustrating the initial lymphocytic phase (A), and the collagenous evolution (B) of the reactive tissues. The sinuous bands at the right side in B are fascicles of nerve fibers reduced to collagenous residues.

Comment

The microscopic examination of the septal and other cardiac tissues of this patient with heart block disclosed an extensive granulomatous destruction of the myocardium in the region of the septum, generally accepted as pathognomonic for the disorders of conduction. The technics of serial sectioning of the septal block tissues horizontally and the staining procedures developed as a means to contrast the nerve elements and some details of their structure, constitute a specific and different approach in the examination of these cardiac tissues of patients with heart block. Large amounts of septal myocardium were destroyed. These included the ordinary muscle tissues, the specialized myocardium of the conductive system; the abundant nerves, both vagal and sympathetic; their nerve fibers, singly or in fascicles; and their perimysial innervation apparatus and terminal arborizations.

Experimental Heart Block Studies

Proponents of the myogenic transmission of intracardiac impulses, unaware or in disregard of the extensive innervation of the ordinary and the specialized myocardium in the septum which with all other tissues has been reduced to collagenous scars, would interpret the changes in this heart as another example of heart block caused by scar tissue interruption of the conductive system. Fibrous scars of septal tissues with spontaneous heart block in the human heart often replace much more than the specialized myocardial tissues; or, as Rossi and others have recorded, heart block may occur without injury of the conductive tissues in the septum.

Reference is made to experimental heart block studies in dogs as a means to clarify some of the conflicting opinions in the role of septal nerve injuries in the pathogenesis of heart block. Erlanger (1906-1910)^{3, 4} produced heart block in dogs by cutting, crushing, or otherwise injuring the septum at the atrio-ventricular level. These procedures and those used by others^{1, 2, 5, 19, 24-28} shortly thereafter, were carried out blindly and injured much more of the septal tissues than those in the conductive system. Since the time of these

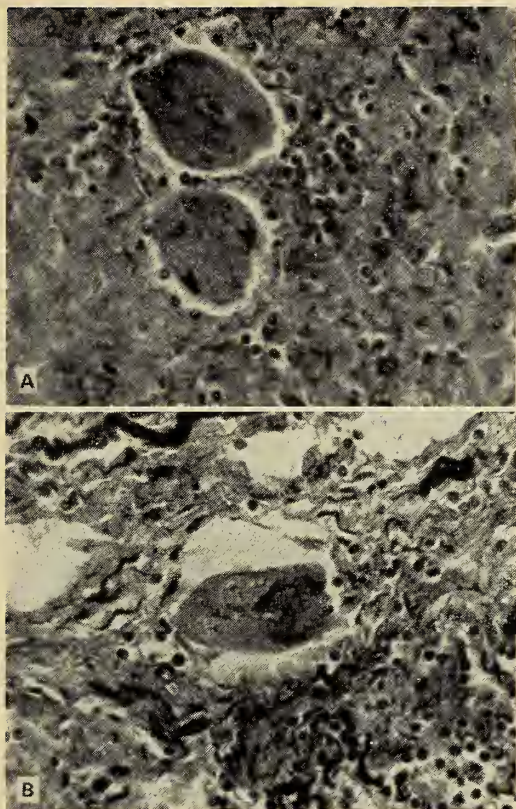


Fig. 5. Photomicrographs (high power) illustrating the giant cells with their inclusion bodies.

experiments, an extensive vagal and sympathetic innervation has been demonstrated in the cardiac septum. The results of our experimental studies of heart block in dogs^{16, 18} with the technics of open heart surgery and with visually controlled, minimal injuries to a critical region in the intra-auricular septum are restated in the following paragraphs.

Heart Block by Surgery

Heart block, confirmed by electrocardiograms, was produced in dogs by open heart surgery. Critical tissues 8 to 10 mm. in front of the atrium of the coronary sinus were injured by an implanted suture, an incision, or a stab wound. At intervals ranging up to one year following the injury, the hearts of these dogs were secured for study. A standard block of septal tissues, generally specified as including the septal elements of the conductive system in the dog or the human heart, was removed for histological examinations. Serial sections of the blocks were cut in the horizontal plane, not the

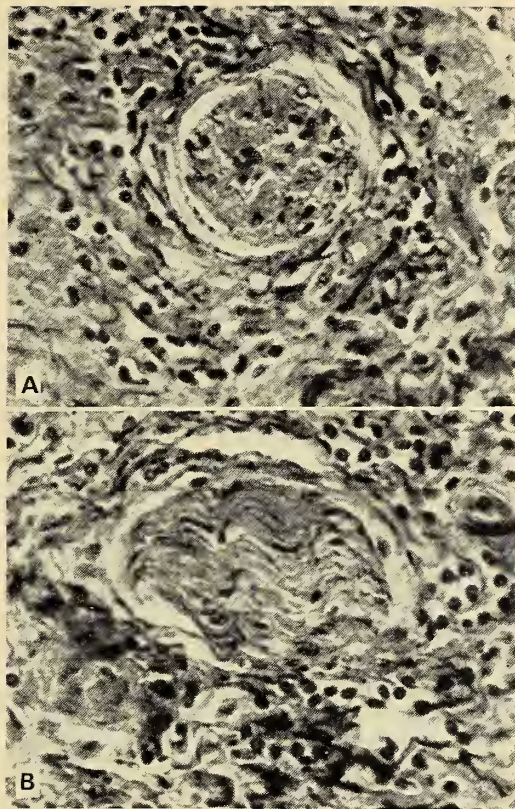


Fig. 6. Photomicrographs illustrating nerves with retrogressive changes, embedded in the collagenous scar tissues.

vertical, and were stained for nerve structures according to a system devised for this purpose.

The atrial septum behind the pars membranacea has a group of large and small nerves associated with clusters of ganglia. These are in close relationship with an ovoid mass of myocardium continuous with the posterior terminus of the right branch of the bundle. Some of these nerves or their branches, fibers and fibrils pass forward with the specialized and the ordinary myocardium; others extend into the ventricular myocardium of the septum.

Retrogressive Changes

The heart block produced experimentally in six dogs was associated with injury and granulation tissue repair of the posterior portion of the right branch of the bundle or its terminus, the ovoid mass of specialized myocardial tissues. Histological examinations demonstrated extensive injury with retrogressive changes of the elements in the

regions injured and in repair. These retrogressive changes included also the loss of the perimysial plexus and interstitial arborizations in the regional myocardium, notably the ventricular.

The injury of the atrial septum which in four other dogs failed to cause heart block, spared the septal tissues with nerves and their associated ganglia, the ovoid mass of muscle in close relationship and the distal terminus of the right bundle branch. The a.v. node, the bundle and the first portions of its right and left branches in two of these septums were extensively destroyed without electrocardiographic evidence of heart block.

Nerve Injury and Cardiac Disorder

These results suggest causal relationships between injury of nervous tissues in the critical region of the atrial septum behind the pars membranacea and the cardiac disorder designated as heart block. The significance and the purpose of the abundant innervation of the total heart in cardiac functions, and specifically of the rich distribution of nerves with and without ganglia in the septal tissues near or including the conductive systems deserve a thorough reappraisal.

The results of experimental heart block in dogs, as stated and brought into perspective for interpretative purposes, suggest causal relationships between injuries of nervous tissues in the critical region of the atrial septum behind the pars membranacea and the cardiac disorder designated as heart block.

The structure of the single and confluent granulomas in the septum corresponds with the description of "isolated" or "Fiedler's" form of myocarditis, as reviewed and recorded by Saphir²² and others. The single and confluent granulomatous lesions as Saphir described them, have foci of necrosis, marginally with many lymphocytes, eosinophilic leukocytes, and a few endothelial cell phagocytes. Giant cells with marginally distributed nuclei are a conspicuous tissue element. Spirochetes or tubercle bacilli have not been demonstrated. The probability that the disorder is a form of chronic infectious myocarditis lurks in these comments.

The evolution of the granulomatous tis-

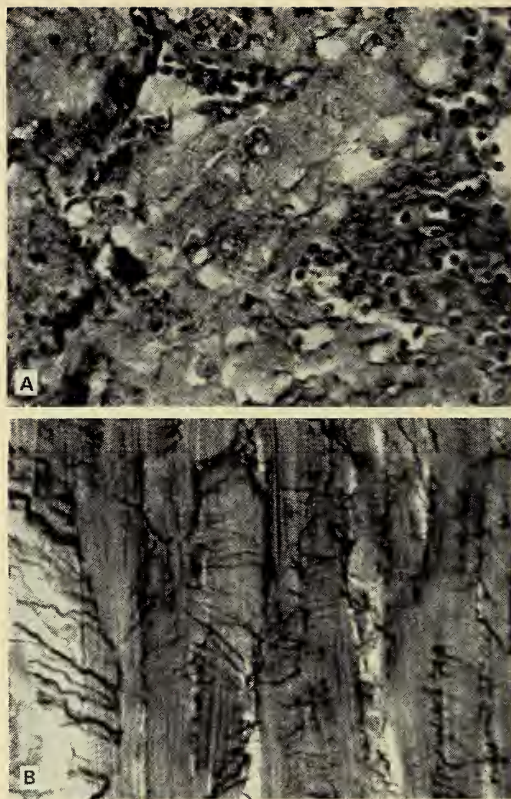


Fig. 7. Photomicrographs (high power) illustrating in (A) the destruction of the conductive tissues in the scars; and in B the perimysial plexus of nerve fibers and fibrils with some terminal arborizations in the myocardium not involved by the granuloma. Nerves, their fascicles of fibers, the perimysial innervation apparatus and the terminal arborizations are reduced in the scar tissue to a collagenous matrix.

ues in the myocardium of our patient seems to progress through an early lymphocytic phase directly into the dense collagenous fibrous. The concept that an infectious agent is responsible poses the possibility that the rounded inclusion bodies in the giant cells could be yeast-like organisms similar to those in this phase of histoplasmosis.

Summary

Histologic examinations of the septal cardiac tissues of a patient with heart block demonstrated an extensive replacement by granulation and scar tissues with numerous foreign body giant cells, and which has been described as isolated granulomatous or Fiedler's myocarditis.

The specific histologic technics with the

staining procedures developed and applied for the microscopic studies demonstrated, along with replacement of the ordinary septal myocardium and of the specialized myocardium of the conductive tissues, an extensive destruction of the intrinsic vagus and sympathetic nerves and their fiber and fibril terminals.

These results, evaluated with those derived from the experimental studies of heart block in dogs, suggest that the destruction

or injury of nerves with and without ganglia in septal tissues near or including the conductive system deserves reappraisal as causal in disorders of cardiac conduction.

This statement does not imply that the conductive tissues have no purpose. Rather, the extensive and elaborate innervation pattern of the heart supports the view that these nervous tissues have a significant role in cardiac physiology in health and disease.

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(Continued on page 248)

The Tension State: Treatment with Audio-Visual Aid

By A. EDWARD LIVINGSTON, M.D./BLOOMINGTON

The patient who has an illness caused by the tension state has very little chance in the average non-psychiatrist's office, whether specialist or generalist, of receiving adequate care. Too often such patients are told bluntly that they have a "nervous condition." If by chance their main complaint is "nervousness," they are usually either advised to forget it or to see a psychiatrist. If the symptom relationship to the tension state is fairly obvious, however, they may be given various medications such as anti-spasmodic agents and tranquilizers. It is true that a conscientious physician may attempt to provide some psychotherapy, but all too often the process is found to be time consuming and monotonous so that adequate treatment is not given.

Faced with the above situation in my own practice, a specific routine lecture was put together that I could give the patient in a reasonable length of time which would at least begin an understanding of the tension reaction for the patient. This discussion proved to be very rewarding. However, it was found that repeating the discussion to two or more patients in one afternoon was extremely tedious to the physician, and consequently a mechanical means of presenting the lecture was sought.

15-Minute Presentation

The solution to this problem was found to be through the use of an audio-visual presentation. This consists of a 33 $\frac{1}{3}$ rpm keyed record and a film strip.¹ These are played on a DuKane sound filmstrip projector.² It lasts about 15 minutes and can be presented as often as desired.

The content of the lecture itself has been

reduced to the simplest terms possible to explain the effects of the tension state. Certain liberties have been taken with known physiological processes in order to simplify understanding. The illustrations themselves are likewise non-technical and serve to produce a certain amount of identity with the patients and the cases cited.

The lecture should rarely be presented to any patient without a complete history and physical examination being done, together with the necessary laboratory work and x-ray studies. After it has been determined that the diagnosis is truly that of a tension illness, and this may take several office calls, if the physician has been careful to explain the results of the examination to the patient, agreement will often be forthcoming from the patient as to the diagnosis. The presentation will then fit in perfectly.

CONTENT OF PRESENTATION

Tension is one of the major enemies of modern man. It is a large factor in every disease process. Such illnesses as peptic ulcer, ulcerative colitis and high blood pressure are partly tension created. Conditions, such as certain types of rheumatism, skin disorders and allergies are likewise associated with it to some degree. In blood vessel disease in the heart, tension may help to cause an attack of obstruction, and death may result.

As it is seen in the doctor's office, however, tension is most often the cause of minor—but distressing—symptoms such as headache, indigestion, constipation, heart consciousness, episodes of weakness, or just plain "nervousness." It is important that such patients be treated too, as these less important complaints can become major in the course of time. The purpose of this presentation is to explain what tension is,

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1. Distributed by Film Distributors International, 2223 South Olive St., Los Angeles, Cal. 90007
 2. DuKane Corporation, Audio-Visual Division, St. Charles, Ill. 60174

how it affects the entire body, and how to cope with it when it occurs.

Tension Like Rubber Band

A person under tension is like a rubber band pulled out as far as it will go. You can see that this affects all the body. How does one get this way? We will show you.

Your body is an automatic vehicle to carry your brain around. As such, it must have controls to make it go faster or slower as need be. These control centers are located in the automatic part of the brain. They are in groups which we call "instincts." The strongest instinct is that of self-preservation. This is the instinct that comes into play when a person becomes frightened; such as, almost having an automobile accident. Fear causes us to tighten up all of our muscles. Our heart pounds, we breathe faster, our skin gets cold and clammy, and we feel as though all of our insides are being squeezed. This reaction occurs to everyone in the same way. It is nature's way of protecting all animals, including human beings.

Heart Beats Faster

Our heart beats faster, driving the blood pressure up so that more blood can be sent to the vital organs of the body to carry more oxygen and food and to take away the waste products. We breathe faster to bring more oxygen into the body to get rid of more waste carbon dioxide. We have a cold sweat as the blood vessels in the skin contract, so that bleeding will be less if injury occurs. Our body becomes tense, getting ready to fight, or run. The stomach, intestinal tract and urinary bladder contract, too, getting ready to get rid of their contents. If the danger seems great, vomiting and/or movement of the bowels with urination may occur. The purpose of this unpleasant group of reactions is to get rid of the food which has recently been eaten and the waste products that are in the bowel or bladder. This is to prevent rupturing of the stomach, bowel or bladder, for (if these organs are empty) it is much more difficult to injure them than if they are full. Also, we became lighter on our feet when these organs are empty so that we can fight or run better.

We can see then that this group of actions affects the entire body. This is cer-

tainly useful to animals in the face of danger, but it is usually merely a source of distress to human beings. Animals only have the fear reaction occur when dangers are actually detected by the sense organs; eyes, ears, nose. The animal brain is composed almost entirely of the automatic center area. The ability of an animal to think is minimal.

The human brain, however, is composed largely of the thinking mind which sits on top of the automatic center area. Our thoughts go right through these centers and can trigger them off. The first time that most of us noticed this reaction was when we first went to school and had to take a test or make a recitation for which we were not too well prepared. We were afraid we wouldn't pass so we had a fear reaction. We couldn't eat well. We felt a cold sweaty feeling and our muscles were very tense. There might even have been an added need to go to the bathroom frequently. After the examination or having made the recitation, we felt well, perhaps a little tired. We soon learned that the same reaction occurred to everyone in comparable situations. We realized that the reaction is normal. In fact, we even joked about it. However, if it occurs too often, or lasts too long, it becomes abnormal.

Nervous System Inherited

Why should this reaction occur too often and last too long to some people and not to others? In the first place, we inherit our nervous system from our parents just as we do the color of our eyes and the color of our hair. If one or both parents tend to be high strung, the children will tend to be high strung, too.

Secondly, if we are raised in a household where both parents are tense, the home will be very active (although not necessarily uncomfortably so), but we won't learn how to relax.

Third, much depends on how we were raised from birth to the age of six years. It is in this span of years that we gain our knowledge of the outside world through our parents' reaction to us. The new born must be fed. If it isn't fed reasonably close to the time that it cries; it gets a feeling that this is a pretty bad world. Hunger is pain to an infant so it has the feeling that

there is pain, but no one will help. If the infant is fed reasonably soon when it cries, it gets the feeling that this is a pretty good world, for when the pain occurs, something will happen that will help.

Display of Affection Necessary

As the child grows, begins to walk, and is exposed to the outside world, he often gets tired, frightened, angry or just plain bored. If his parents are around to display affection (and affection must be displayed to the child, as at that age the word "love" is not understood), he gets the feeling that, when something bad happens, someone (or something) will be around to help him.

If enough display of affection occurs, we tend to build up a large security. Basic security can be represented by a cushion that we always carry around behind us. If we have a lot of basic security, the cushion is thick, so that when we do get pushed around by the outside world and fall, we don't get hurt much. So, we have the feeling that "things are bad now, but something good will happen to make them better." On the other hand, if we have too little basic security, our cushion is thin. Then, if we get pushed by the outside world and fall, it hurts. We get the feeling of "things are good now, but something is going to happen and I am going to get hurt," a nameless fear. This causes us to have a fear reaction, which produces constant tension.

Different Kinds of Symptoms

Continuous muscle contraction, or tension, will produce many different kinds of symptoms, as we've already seen. It may cause fatigue, as a person with severe tension will actually use more energy sitting in a chair than many people do when working. It also interferes with sleep. It may cause headache by muscular pull on the scalp. This is the most common of headache. It may cause chronic stomach trouble or "acid indigestion" due to overactivity of the stomach and its glands. It may cause loose (or tight) bowel movements. It can cause irregular heart beats, also too rapid heart beats. It is involved in spells of faintness, dizziness and tingling of the hands and feet due to rapid breathing and loss of

too much carbon dioxide. There are many different expressions of the tension state. Let us examine some specific cases.

John Jones was in college at the start of the last war. He enlisted in the marines and was sent to Officers' Candidate School. He was from a well-to-do family and had every advantage money can buy. His father was a prominent executive, very busy, who needed to travel a great deal. When the parents were gone, John and his younger brother were cared for by well-trained nurse maids. They saw their parents only on weekends, for the most part. John was a good student and did very well at the Officers' Training School. When he was sent overseas, he was put in command of a battalion. Upon landing and being subjected to enemy action, however, he became very ill with vomiting and severe stomach pains, so much so that he could not lead his troops.

No Physical Disorder

He was finally sent to the hospital. No actual physical disorder could be found, so he was returned to duty. The same thing happened again. Upon returning to the hospital, it was found that there was no change in this reaction; so he was returned to the training school to teach.

In John's battalion, there was a sergeant—Sam Smith. He was part of a large family, with three brothers and two sisters. He was the third child. His father was a plumber who did moderately well with his work. His mother took care of the family. They had all they needed but few luxuries. Sam became an apprentice plumber. Sam did well at the marine training camp, was promoted to sergeant and later shipped overseas with John. When John became incapacitated during the first attack, Sgt. Smith immediately took over command and successfully rallied the troops so that the attack went forward as ordered. For this he was promoted to second lieutenant on the battle field.

Domestic Type of Case

As can be seen from this story, basic security difference can change responses to situations drastically. Let's look at a domestic type of case. Mrs. Fussbutts was the wife of an important officer in a large cor-

poration. They were married when he was just beginning as a junior executive. They had two children. During the early years she was busy raising the children and generally keeping house. As the children became older and went away, she found herself with less to do. Her husband also was becoming more and more involved in his work and had to travel about the country a lot. Although she worked at community activities, she was often by herself. She began to have headaches, mild at first, but gradually getting worse. One day her husband called her and said he couldn't get home for the weekend as he had to go to London immediately. That evening she had a very severe headache with nausea and vomiting. She called the doctor who gave her some medication, but she became no better. The doctor then put her in the hospital. She requested that her husband be called. This was done, and he came at once to the hospital and was with her for the next few days while tests were being made. Her children also came home. Nothing unusual was found through examination. However, she felt much improved when she left the hospital.

Headache Returns

When she returned home, her husband and children left once more. About a week later, her headaches returned, becoming very severe again during the next month. She became very frightened. Because of this, her husband insisted that she be sent to a famous clinic for examination. Again, nothing was found. Upon returning home, the headaches resumed. She began to take all sorts of medication and to go to various types of clinics, quacks, etc. None of these particular healers helped her. She was finally referred to a neuropsychiatrist. No brain tumor or anything of that sort could be found.

It was determined, however, that her mother also had headaches. Her father was a formidable individual who dominated her mother. There was little love expressed in the family. Her mother frequently retired to her room for days with "migraines." After some psychotherapy, Mrs. Fussbutts was somewhat better, but her headaches returned. Then, her husband received a promotion to vice president. He no longer

had to travel constantly. He was home a good deal of the time and when he did travel, he could take his wife with him. Now, Mrs. Fussbutts, although she had occasional mild headaches, was much better. This case illustrates the difficult situation of secondary gain. Although this reaction seems purposeful, it is not. It is entirely unconscious. Once Mrs. Fussbutts' family life became more normal and pleasant, she improved.

Understanding Eases Treatment

Now, if the two people we've described (Lt. Jones and Mrs. Fussbutts) understood what could happen to them before it occurred, treatment would have been much easier, and possibly unnecessary. It's easier to treat the tension state before it occurs. We would then avoid placing undue importance on relatively minor symptoms. We all would realize that if we get pushed around too much by the world we may develop actual physical disorders, then we won't allow our tensions to get out of hand.

Treatment, however, can be quite effective if it is begun soon enough. Take the case of Jane Johnson, age 22, married about one year with one child. Jane works in a variety store. She began to have spells of faintness with marked pallor and extreme anxiety. With this, there was also chest pain, rapid heart beat and difficulty getting a deep breath. When they occurred, she was sent home from work. She was completely examined. It was determined that her symptoms were caused by too rapid breathing with a resultant disturbance in her body's chemical balance. This was caused by tension. Jane was the youngest of three children. Her mother divorced her father when Jane was two and was then remarried two years later. The home was generally happy despite the previous marital difficulty. The stepfather proved to be a good parent. Despite this, Jane still had had her security disturbed, so that small problems could cause severe anxiety. When this was explained to her in detail she became much better, although on occasion she would still have some difficulty.

You can see, therefore, that if you understand this discussion, you will be well on your way to freedom from many illnesses

(Continued on page 204)

Dysmenorrhea and Pre-Menstrual Tension In Adolescents

By LESTER A. NATHAN, M.D. / SKOKIE

Physicians who treat adolescent girls are well aware of the high incidence of menstrual disturbances, notably dysmenorrhea. There is a tendency to place considerable reliance on reassurance in medical management of these patients. Reassurance is of little value in highly emotional subjects unless reinforced by measures for relief of pain and distress. We agree with Baldwin who reports little success in treating dysmenorrhea with psychotherapy, liberal use of exercise, good diet, and the like recommended in the common textbooks.¹ Unquestionably, emotional factors play a significant role in menstrual irregularities, but there is not a higher percentage of neurotics among dysmenorrheic females, the psychic component being symptomatic rather than etiologic.^{2, 3}

It is well established that dysmenorrhea is seen most frequently in individuals who have a low pain threshold.^{4, 5} The chief demand of the patient is for relief, and there is little to be gained by telling her that her menstrual disorders are psychogenic or that she has a low pain threshold.^{6, 7} This is of particular importance in adolescents. As Foster⁸ has put it so aptly: "A second element is the inevitability of future pain and incapacity. It is small wonder that the women of 20 overacts to the prospects of 300 similar episodes during the next 25 years of active menstruation." This factor has also been stressed by Menzer-Benaron.⁹

While the etiology of dysmenorrhea is still unclear, present day medical management is effective when four control measures are emphasized: 1. general health measures; 2. immediate pain relief; 3. inhibition of ovulation, and 4. surgical procedures.

For obvious reasons, the use of narcotics, or narcotic containing analgesics must be avoided in treating adolescents. We have recently evaluated a nonnarcotic analgesic compound* in treatment of dysmenorrhea, found it highly effective, and report here on our experiences in 51 patients.

Methods and Materials

All were ambulatory office patients, age range 10 to 18 years. The major complaints were primary dysmenorrhea and/or premenstrual tension. Patients with secondary dysmenorrhea, or in whom there was suspicion of organic disease were not included. Pain was the primary problem and the major complaint. In addition, cramping (usually severe), "jitters," headache, nausea and edema were common. All had previous therapy, usually with a variety of agents, with varying degrees of success. There was the usual high incidence of absence from school or work.

In addition to the usual hygienic measures, all patients were given the new analgesic compound, the usual dose being one tablet four times daily. The duration of therapy ranged from one to four days. No additional drugs were given. At the start of

Presented as a Scientific Exhibit at the Illinois State Medical Society Meeting, Chicago, May 16-18, 1966.

*Norgesic®-Riker Laboratories, Northridge, Cal. Each tablet contains orphenadrine citrate 25 mg., aspirin, 225 mg., phenacetin, 160 mg., and caffeine, 60 mg.

the study the standard Norgesic formula was used. During the course of the study a modified formula was made available*, and was used during the balance of the study.

Results

Response was graded upon the reports of the patient, plus those of the mother, coupled with clinical observation, and was rated as being either satisfactory or unsatisfactory. A satisfactory response comprised excellent to complete relief of pain, absence of marked side effects, and a better overall response by comparison to previous therapy. By these criteria, a satisfactory response was seen in all patients.

Side Effects

Side effects were minor and infrequent. There was complaint of mild euphoria in one patient (18 years, dysmenorrhea plus intercostal neuralgia). There were occasional minor reports of gastric upset. Side effects were not sufficiently serious to warrant discontinuing the therapy in any patient, and were usually milder than had been reported for previous therapy.

Discussion

While the use of effective nonnarcotic analgesics is highly effective, this does not preclude the necessity for careful explanation to the adolescent patient of the nature of her problem, the necessity for reassurance, and also the institution of hygienic measures. Misconceptions about menstruation, usually stemming from folklore, must be corrected. The adolescent should be reassured that clock-like regularity of the menses may not be achieved for several years after the menarche. Foster⁸ reports that the average girl starting menses does not ovulate until roughly 40 periods have passed. This has also been stressed by Greene and Duhrig.¹⁰ While the functions of the bladder and bowel are basically excretory, this is not true of menstrual function and that scanty or absent menses does not mean that poisons are being stored up in the body.

He further emphasizes that since childhood, pain and bleeding is a danger signal. Reproductive function is a cherished possession of women, and pain associated with bleeding may subconsciously suggest damage to this possession, this may be deeply disturbing. Reassurance by the physician, coupled with immediate and adequate control of pain are vitally essential.

It is well established that the pain of dysmenorrhea is due to muscle cramping. In 1942 Bickers utilized kymographic tracings of uterine contractions to demonstrate that the uterus was normotonic in normal women. During the premenstrual and menstrual phases, high amplitude contractions were noted. In patients with painful menstruation these high amplitude contractions were superimposed on the spastic myometrium with elevation of the baseline. This tetany could be abolished predictably only by morphine and only occasionally with the spasmolytic drugs then available.¹¹ Moir had previously reported similar findings.¹²

Hayden¹³ discussing the management of primary dysmenorrhea, states that if one assumes that hypercontractility of the uterine musculature is the primary etiologic factor in the mechanism of pain then the basic aim of a good therapeutic agent would be the reduction of uterine contraction.

The superior pain relief seen with the new combination is due to the use of an effective nonnarcotic analgesic plus a muscle relaxant.

That the analgesic action is augmented when orphenadrine citrate is combined with APC has been shown by McClure¹⁴ who demonstrated marked potentiation of analgesic response as well as duration of action when orphenadrine citrate was added to A P C. Anticholinergic-antispasmodic drugs have been shown to be effective in dysmenorrhea, and have been used extensively. Since orphenadrine citrate has both anticholinergic and antispasmodic action, this also accounts for the excellent response seen with this new combination.

The dosage (one tablet three-four times daily) is simple, and the low incidence of side actions makes this a helpful medication for adolescents. The elimination of phenacetin in the improved formulation is an additional advantage.

*Riker 729, Riker Laboratories, Northridge, Cal. Each tablet contains orphenadrine citrate 50 mg., aspirin, 770 mg., and caffeine, 60 mg. (an experimental product).

Conclusions

1. A nonnarcotic analgesic, Norgesic and/or Riker 729, has been used for treatment of dysmenorrhea in 51 adolescent girls. This has been combined with the standard measures

of reassurance, careful explanation of the problem, and institution of hygienic measures.

2. The response was satisfactory in all patients.
3. Side actions to the drug therapy was not a problem.

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Hospital Opens E.M.G. Laboratory

St. Joseph Hospital, Chicago, has announced the opening of an Electromyography and Electrodiagnostic Laboratory which is equipped to perform electrical diagnostic studies in disorders of nerves and muscles.

Presiding over the forward looking unit is Dr. Norman B. Dobin of the St. Joseph Hospital section of neurology. The E.M.G. laboratory is located in the hospital's third floor section of neurology adjacent to its electroencephalography laboratory and is available for both in-patients and out-patients, including clinic referrals.

The laboratory is equipped with the following apparatus: a Square Wave Constant Current Galvanic Stimulator for determining Rheobase, Chronaxie, Tetanus Ratio, Repetitive Stimuli Curves, Strength Duration Curves and Faradic responses; 2) an Electromyograph and 3) apparatus for Nerve Conduction Time and Velocity Studies.

Toxic Epidermal Necrolysis

(The Scalded Skin Syndrome)

By E. PADNOS, M.D. AND S. J. ZAKON, M.D. / CHICAGO

In 1956, Alan Lyell¹, of Aberdeen, Scotland, published four case reports of a toxic eruption which closely resembles scalding in its clinical appearance and in the sensations to which it gives rise in the patient. Lyell stated that it is probable that this type of reaction is not uncommon and that it has been classified as a toxic reaction, erythema multiforme with bulla, or some other bullous eruption. However, the features of toxic epidermal necrolysis are so definite and they concern the epidermis so intimately that it is important to recognize this syndrome as a distinct entity in which some circulating toxin specifically damages the epidermis and results in its necrosis.

Although more than 150 cases of this startling dermatosis have been reported in the world medical literature, only a few such cases have been reported from America since 1960, and most of these have been in the specialty journals. It is likely that this syndrome is still not widely recognized in the United States. Therefore, the following classic example of this syndrome (Lyell syndrome—the scalded skin syndrome) is deemed worthy of publication for the purpose of familiarizing the general practitioner with this alarming dermatosis, where early diagnosis and proper management is extremely important and often life-saving.

Case Report

R. D., a five and a half-year-old white girl was admitted to Mount Sinai Hospital Medical Center of Chicago on Dec. 4, 1965. Fourteen days prior to her admission to the

hospital she had a severe attack of a febrile upper respiratory infection, accompanied by frontal headache and a sore throat. Physical examination revealed red, inflamed, enlarged tonsils, palpable cervical nodes, and generalized harsh breath sounds. Throat cultures were negative for Beta hemolytic streptococci. She was treated with Terramycin (oxytetracycline), 125 mg. q.i.d., a simple cough mixture and aspirin. After six days on the above medication she improved and medication was discontinued.

Past History

This child was under the care of Dr. E. P. since her birth on June 18, 1960. At six and a half months of age she suffered an attack of bronchial asthma, following an upper respiratory infection associated with a nasal discharge, and a rectal temperature of 102° F. During the next two years she had recurrent upper respiratory infections associated with nasal discharge, pharyngitis, tonsillitis and a cough. At various other times she had attacks of expiratory wheezing.

At the age of 26 months she developed an erythematous vesiculobullous eruption of the neck, trunk, and hands due to contact with a poison ivy plant.

Because of her recurrent attacks of bronchial asthma throughout the year she was skin tested in June, 1963. Following elimination of a few foods and environmental control, she received pollen dust and molds hyposensitization therapy, which benefited her greatly. Her attacks of asthma and upper respiratory infections became less frequent.

In 1963 she developed a generalized

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macular erythematous eruption following the use of Gantrisin (Sulfisoxazole) for an upper respiratory infection and three months later she developed angio-neurotic edema following the use of penicillin for a Beta hemolytic streptococcus throat infection.

In the past two years she was receiving hyposensitization therapy with fluid extracts and was much improved until the present illness.

On Dec. 3, 1965, the child complained of severe burning on urination. Her mother then observed a red, denuded area of the inner surfaces of the labia majora, and a generalized redness in the ano-genital area. Within 24 hours a beefy, red, erythematous rash appeared on the neck, the peri-orbital areas of face, forehead and ears. The child kept her head tilted as moving the neck was painful.

Subsequently, the eruption involved the axilla, shoulder, thorax, hands, legs and feet. The epidermis of the involved areas separated in sheets, leaving a beefy, red, weeping surface. The slightest touch of the skin elicited a positive Nikolsky sign.

On admission to the hospital the child was in discomfort and looked apprehensive. The epidermis had separated from the neck, ears, forehead, axilla, upper thorax and ano-genital area. She had a gray, membranous tonsillitis, enlarged anterior cervical glands, and erosions along the margins of the tongue. All other physical findings were essentially negative. Temperature was normal and remained normal throughout the course of her illness.

Laboratory Findings

On admission, WBC count was 8,650 with 73 polymorphonuclear leukocytes, 21 lymphocytes, 1 mononuclear leukocyte, 5 eosinophils. The hematocrit was 43%, hemoglobin 11.4 Gm./100 ml. Six days later the WBC count was 18,100 with 75 polymorphonuclear leukocytes, 4 stabs, 19 lymphs, 2 monos. Hematocrit 37.5%, hemoglobin 12 Gm./100 ml. Cultures obtained on admission for the throat and the denuded areas of the skin yielded heavy growths of staphylococcus aureus, coagulase positive. The organism was highly sensitive to penicillin, erythromycin, novobiocin, oleandomycin, oxacillin, lincomy-

cin, chloromycetin and tetracycline. The first urine analysis showed a trace of protein, but subsequent urines were normal. The sedimentation rate (Wintrobe) was 10 mm./hr. micromethod. Chest x-ray was essentially negative.

The exact cause of toxic epidermal necrolysis is not known. However, drugs are incriminated and it is assumed that this syndrome represents a drug hypersensitivity reaction. This is not always true, since this syndrome may occur in patients who have not received any medication or immunization therapy for many months prior to the eruption.

Therapy

On admission the child was placed on Prednisone 10 mg. q.i.d., Periactin 4 mg. t.i.d., erythromycin 250 mg. q.i.d. and topically Cortdome lotion to the denuded areas b.i.d. Within the next 48 hours a remarkable improvement of the skin lesions and mucous membrane lesions was observed and the dosages of prednisone and erythromycin were gradually decreased. The red, moist areas of the affected skin began to heal as erythema and desquamation diminished. She was discharged on the 7th hospital day with almost complete healing of the involved skin.

Ten days after discharge from the hospital the child was examined by Dr. E. P. and the skin appeared normal.

Comment

The cardinal signs and features of toxic epidermal necrolysis⁴ are:

- 1) Tender erythematous skin, painful to touch.
- 2) Areas of predilection are neck, face, inguinal region of axilla.
- 3) Desquamation of the epidermis leaving a beefy red moist surface.
- 4) Nikolsky phenomenon easily demonstrated.
- 5) Rapid re-epithelization of denuded areas.

Toxic epidermal necrolysis differs from the bullous diseases such as pemphigus, erythema multiforme bullosum, in that bullae are seldom observed in toxic epidermal necrolysis. The serous fluid just undermines the upper layer of the epidermis. Large tense bullae are not common or

characteristic of this syndrome. The syndrome is distinct from Stevens-Johnson syndrome, since the mucous membrane lesions form a prominent feature in Stevens-Johnson and a minimal role in toxic epidermal necrolysis. Ritter's disease of the newborn is bullous impetigo and so-called Butcher's pemphigus is a bacterial septicemia².

Pathology

Microscopic sections³ of the skin in toxic epidermal necrolysis reveal lines of separation in either the keratin layer or between the keratin and granular layers or

between the granular and malpighian layers. The dermis is not involved; however, there is dilatation of the small blood vessels in the upper dermis with lymphocytic infiltration.

Therapy

Broad spectrum antibiotics to prevent secondary infection, steroids⁵, and good nursing care are the life-saving measures in this startling dermatosis. Since deaths have been reported in those cases where steroid therapy was withheld, we strongly urge early diagnosis and early therapy with steroids.

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Portable Kidney Machine Developed in Wales

Successful trials of a new, portable automatic kidney machine, which could free hospital nurses for other duties and alleviate a shortage of kidney machines, have just been completed at the Cardiff Royal Infirmary in Wales. Built by the Industrial Automation Division of Hawker Siddeley Dynamics Ltd., in association with Dr. G. A. Mallick and Dr. G. A. Coles of the Welsh National School of Medicine, the machine will cost about \$2200 when full production is reached in May or June of 1967.

To be called the Cardiff machine, the equipment uses the peritoneal dialysis technique. In this treatment of patients with kidney failure, a dialysis fluid is pumped into the peritoneal cavity. Waste products, normally extracted by the kidneys, pass from the numerous blood vessels in the peritoneal lining into the liquid by a process called dialysis. The liquid is then removed from the patient and the cycle repeated. This technique is simpler than the best-known method for removing the

waste products, in which the patient's blood is washed as it passes through a machine.

Previously the repeated peritoneal dialysis liquid changes have been made every hour by a nurse who has had to be in constant attendance for 12 to 24 hours. The new machine has been designed to conduct the sequence automatically and safely, and as comfortably as possible, over a period of up to 24 hours, reducing the need for constant observation of the patient by a nurse. Temperature and pressure of the dialysis fluid is monitored as it is automatically pumped to and from the patient, and the amount of liquid transferred is continuously recorded. Fail-safe alarms operate under emergency conditions.

Complete sterility is maintained for the patient by means of assembling into the machine a pre-sterilized pack of plastic tubing which is subsequently discarded. This eliminates the need to sterilize other parts of the machine since the aqueous solution is completely contained in a sterile environment.

A Case Report

Schistosomiasis

By PAUL W. YARDY, M.D. / URBANA

It is remote that schistosomiasis would ever become an endemic problem in the United States. Still, the physician in this country may well have occasion to deal with this condition in his own office practice. The wide prevalence of this parasitic disease is second only to malaria, vying possibly with ancylostomiasis for that distinction. It is estimated that schistosomiasis affects between 200 and 300 million people today in tropical and subtropical areas of the world. Actually, the incidence might well be on the increase because of expanding irrigation systems in endemic and potentially endemic areas.

The U. S. physician's concern in this disease will be in at least two circumstances. He will be advising his patients who plan to travel abroad in infested areas regarding preventive measures. He must also keep in mind the possibility of the presence of this disease in patients who have returned from such areas and in foreign patients visiting in this country.

As might be expected, the chances of making the diagnosis of schistosomiasis runs greater in college and university health centers where the concentration of international students is relatively high. The following case illustrates this point.

Case Report

J. A., a 25-year-old male national of Nigeria, West Africa, reported at the Health Service of the University of Illinois, Urbana, Oct. 18, 1965, complaining of mild vertigo. During the work-up the urine was microscopically examined and 15-20 WBC per high power field and 40-50 RBC per high power field were found. No growth was found on culturing the urine. The pa-

tient had no complaint relative to the urinary tract.

In spite of a course of Gantanol, the WBC's and RBC's persisted in the urine. An I.V.P. was performed on Jan. 11, 1966. The upper urinary tract showed normal visualization, but there was a suspicious evidence of a polypoid tumor in the urinary bladder. The urine was then spun down and a search made for parasitic ova. Schistosoma haematobium ova were reported found on Jan. 14, 1966.

During cystoscopy on Feb. 26, 1966, an ulceration of the bladder wall was observed and viable miracidia were demonstrated in material obtained from the ulcer.

Effort was made to obtain a supply of the much-publicized, new schistosomicide, Ciba Ambilhar, for treating this case. Failing to find this drug on the market in the United States, the use of Furadin was resorted to. The patient was given 65 cc (6.3%) of Furadin, by intramuscular injection, divided over a period of two weeks, following which the urine became free of ova and microscopic WBC's and RBC's. A repeat I. V. P. on June 6, 1966, was done. Complete disappearance of the previous polypoid defect in the urinary bladder was noted.

Comment

During the laboratory work-up on this patient a parasite was incidentally noted during the viewing of a peripheral blood smear. This was identified as *Loa Loa*. Repeat daytime, thick-blood smear examination revealed many more parasites. A course of diethylcarbamazine cleared the blood stream of this infestation. The latter condition is mentioned to point out the importance of being aware of the possibility of the presence of more than one parasite in the same individual and thorough study is important.

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Allergy and the Pregnant Woman

DONALD L. UNGER, M.D., LEON UNGER, M.D.,
AND DONALD E. TEMPLE, M.D. / CHICAGO

We all know that women are unpredictable, but nowhere is this more apparent than in the allergic woman who becomes pregnant. Some get better, some get worse, and others just get larger¹. Some seem to get pregnant every ragweed season just to avoid having hay fever. While others have extreme allergies from almost the moment of conception until shortly after delivery. A woman may have four perfect pregnancies and extreme asthma with a fifth, or be miserable for the first four and fine with a fifth. There is a tendency towards consistency, however, with the severity of the allergy in the first pregnancy usually being duplicated in the later ones.

While few exact statistics are available,²⁻³ it appears that most allergic women improve during pregnancy, but a few are much worse.⁴ These few may require heroic methods of treatment, especially for status asthmaticus. We know of one woman who was finally sterilized after six consecutive almost lethal pregnancies, because of the severity of her asthma; she was almost asymptomatic when not pregnant. Women with atopic dermatitis ("Eczema") often thrive on pregnancy, when their skins may look better than at no other time in their lives; on the other hand some have extreme flare-ups when pregnant. Therapeutic abortions have been performed on occasions, but in our opinion are not indicated either in atopic dermatitis or asthma.

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The use of drugs for the pregnant asthmatic may present a problem. Medicines might well be avoided in women who have few or no symptoms. Iodides may produce a large goiter in the fetus and result in a stillbirth.⁵ Tetracyclines may stain and perhaps damage the teeth and bones of the fetus,⁶ and are best avoided. Steroids should be used with even more care in pregnancy than otherwise.⁷⁻⁸ At the time of delivery the patient might need increased amounts of steroids, just as would any steroid patient facing an operative procedure. Aerosols and sympathicomimetic agents are the mainstays of symptomatic treatment of asthmatics, whether pregnant or not.

What about the woman who has received allergy injections for some years and is now pregnant? While there are a few documented cases of premature deliveries following hyposensitization in the older literature,⁹⁻¹⁰ we know of no such reports in recent years. With the number of miscarriages and the number of allergy injections, it is surprising that there is not an occasional interrelationship between the two purely on a chance basis. The sensitized uterine muscle of the guinea pig contracts in the presence of the appropriate antigen (Schultz-Dale experiment), so we know that uterine stimulation is possible on an allergic basis.¹¹ Some women describe contractions just like having a baby, during systemic reactions to hyposensitization injections. We join many allergists who recommend cutting dosage perhaps 25% and who maintain the injections at three-four week intervals during pregnancy; we know of no reactions on such a schedule.

A few words should be written about a strange syndrome—the pregnant running nose¹. There are some women whose noses run throughout their pregnancies, but rare—
(Continued on page 210)

Recent Advances in the Treatment of Cancer

FRANCES E. KNOCK, PH.D., M.D./CHICAGO

Surgery and radiation therapy are the standard clinical treatments for cancer. Despite earlier and earlier diagnosis and treatment during the past generation, survival statistics for the common cancer threats have failed to improve. The woman with breast cancer or the man with lung cancer treated only by surgery and radiation therapy has received just those cancer treatments whose failure to improve survival statistics has become clear since World War II and before.

Surgery and radiation therapy are local treatments for a disease that is all too frequently disseminated when the patient is first seen by his physician. For progress, sound local treatment must be supplemented by sound generalized treatment for the patient's generalized disease; by sound drug treatment and vaccine therapy, for example, to attack cancer cells in brain, bones and liver present at the time of diagnosis or spilled out into the patient's circulation during cancer surgery.

If cancer surgery does not encompass the patient's disease, the very stress of surgery may cause nests of cancer cells outside the surgical field to grow at an accelerated rate. The fears of many patients that cancer surgery will make their cancers grow faster, will be realized frequently unless sound generalized treatment supplements sound local treatment by surgery and radiation therapy.

Other than transient pain at the site of injection, autogenous vaccines for cancer have produced remarkably few side effects. The dangers of improper cancer chemotherapy, however, must not be forgotten.

From the Department of Surgery, Presbyterian-St. Luke's Hospital, Chicago; the Surgical Service, Veterans Administration Hospital, Hines, and the University of Illinois College of Medicine.

The wrong choice of drugs for treating a depleted patient after cancer surgery can injure the patient needlessly or even kill him by harming wound healing, depressing bone marrow, decreasing the patient's resistance to his own tumor or enhancing growth of the tumor. Thereby the physician faces a monumental scientific and ethical dilemma from the injury he may inflict needlessly on the patient.¹

At present, cancer chemotherapy is probably the most chaotic therapeutic problem known. The chaos can be expected to continue until sound chemical methods of matching drug therapy to the requirements of each patient's cancer replace our present randomized allotment of cancer patients to toxic chemicals.

Fortunately, cancer chemotherapy matched to the chemical needs of the patient's own cancer cells can be used immediately after major cancer surgery.^{2,3} Such chemotherapy matched to the requirements of the patient's own tumor can regress cancer without injury to wound healing or to hematologic status, or with actual improvement in hematologic status, as illustrated below.

Methods

All patients receive full benefit of aggressive surgery, radiation and endocrine therapy along with chemotherapy directed by sensitivity tests run on their own tumors. Autogenous vaccines are also given to those patients deemed to possess an intact reticuloendothelial system capable of responding to vaccine therapy.^{2,3}

Whenever possible, chemotherapy is given along with radiation therapy, and not after radiation therapy. Patients given chemotherapy after a full course of radiation therapy are almost certainly denied the benefits of chemotherapy, since radiation

endarteritis prevents access of drugs to the tumor. This unfortunate effect can often be seen at the operating table after placement of intraarterial catheters for infusion of drugs. Injection of fluorescein followed by ultraviolet irradiation almost invariably shows marked fluorescence above and below the radiated area with little or none in the area of radiation therapy, to confirm the poor access of drugs to irradiated areas.

The sensitivity tests used to direct cancer chemotherapy postoperatively resemble antibiotic sensitivity tests. Immediately after surgical removal from the patient, his tumor is dissected free of normal tissue and minced in proper tissue culture media containing human serum. No drying; contamination; leaching by saline, glucose, formaldehyde or other noxious media can be tolerated, lest the sensitivity tests be rendered meaningless. Results are read by midnight of the day of surgery. Details of the surgical manipulations, tissue culture and chemical work have all been published.²⁻⁴

Animal cancers whose sensitivities to the drugs being tested are known at the given time must be run side by side with the patient's cancer to serve as control. Results for the given patient's tumor can thereby be expressed in terms of greater or less sensitivity for the patient's cancer relative to known sensitivity of the control animal cancer to the given drug or combination of drugs.

Results

The sensitivity tests used on the present program have agreed with statistically significant results of drug assays against animal cancers for a wide variety of drugs, both active and inactive.¹⁻⁴ In two series of patients, those of Watne and DiPaolo⁵ and those of Knock,¹⁻⁴ test results have correlated well with clinical results from drug therapy "for a specific tumor, in a specific patient, at a specific time."⁵

The national three tumor mouse screen indicated lack of promise for the sulfhydryl (SH) inhibitor oxophenarsine, so the drug was dropped from consideration for human cancer therapy. The sensitivity tests on a variety of human carcinomas and sarcomas indicated promise of the drug, especially when used with adjuncts malonate, heparin and fluoride. In accord with sensi-

tivity tests on each patient's own tumor, the drug has now been used clinically to regress a variety of human cancers.

Over 60 patients have now been treated with the sulfhydryl inhibitor oxophenarsine plus adjuncts malonate, heparin and fluoride, most within 24 to 48 hours of major cancer surgery.^{2-4, 6, 7} The simultaneous use of aggressive cancer surgery and radiation therapy prevented assignment of credit to any one therapeutic method, in thirty two of these sixty patients. Of the 28 who could be followed objectively for effects of chemotherapy, 24 of the 28 experienced objective regression of their cancers from chemotherapy with the sulfhydryl inhibitors alone or in combination with other anticancer drugs, such as alkylating agents, antimetabolites and antibiotics. Of the 17 who could be followed objectively for just the effects of the sulfhydryl inhibitors, 14 ex-

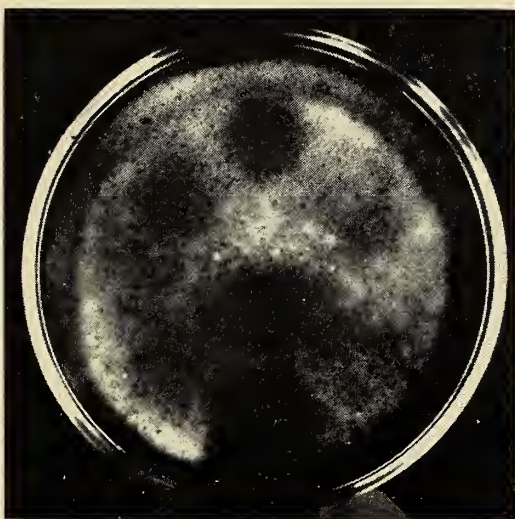


Fig. 1. Sensitivity test on the cancer of a woman with disseminated disease from primary in the sigmoid colon. The larger or more intense the dark area in these tests, the more active is the given drug or drug combination at that spot against the tumor, which is spread uniformly throughout the agar plate photographed. This test for cancer drug sensitivity resembles the usual disc tests of antibiotic sensitivity. Most active drug combination here is seen at 6 o'clock and is the combination of sulfhydryl inhibitor oxophenarsine with adjuncts malonate, heparin and fluoride plus 5-fluorouracil, whose activity exceeds that of oxophenarsine plus adjuncts immediately above or of oxophenarsine at 12 o'clock or of 5-fluorouracil at 7 o'clock. In other assays on this patient's tumor, newer sulfhydryl inhibitors⁸ exceeded oxophenarsine in activity.

perienced objective regression of their cancers. Long term data on clinical use of the sulfhydryl inhibitors cannot be given since available drugs cannot be used for maintenance chemotherapy.

The histories of four patients are presented, to illustrate various facets of clinical cancer chemotherapy with the sulfhydryl inhibitors.

Report of Cases

Case 1. A 70-year-old woman underwent a palliative bowel resection to relieve an impending obstruction of the sigmoid colon from an adenocarcinoma metastatic to both lobes of the liver and multiple abdominal nodes. Agar plate assay on her resected tumor is shown in Fig. 1.

In these tests, the larger the dark area or the greater its intensity, the more active is the drug or drug combination at that position against the patient's cancer cells spread uniformly throughout the agar. The most active drug combination is that at 6 o'clock, the combination of oxophenarsine with adjuncts malonate, heparin and fluoride plus

5-fluorouracil, whose activity exceeds that of oxophenarsine plus adjuncts immediately above. Far less active are other alkylating agents and antimetabolites frequently used for anticancer chemotherapy, present at other positions in the test.

The patient underwent a course of adjuvant chemotherapy consisting of three weeks of daily intravenous chemotherapy with oxophenarsine (120 mg/day), heparin (50 mg/day) sodium fluoride (40 mg/day) and disodium malonate (500 mg/day) with 5-fluorouracil added in the second and third weeks at 10 mg/kg. Effects of chemotherapy were indeterminate since no objectively measurable masses of cancer could be palpated postoperatively.

Four weeks after completion of the first course of chemotherapy, the patient was readmitted for a two weeks course of repeat chemotherapy with sulfhydryl inhibitors plus 5-fluorouracil, at the same dose. The patient's previously normal enzyme levels were now abnormal: isocitric dehydrogenase of 4700; serum glutamic-oxaloacetic transaminase of 280 and sorbitol dehydro-

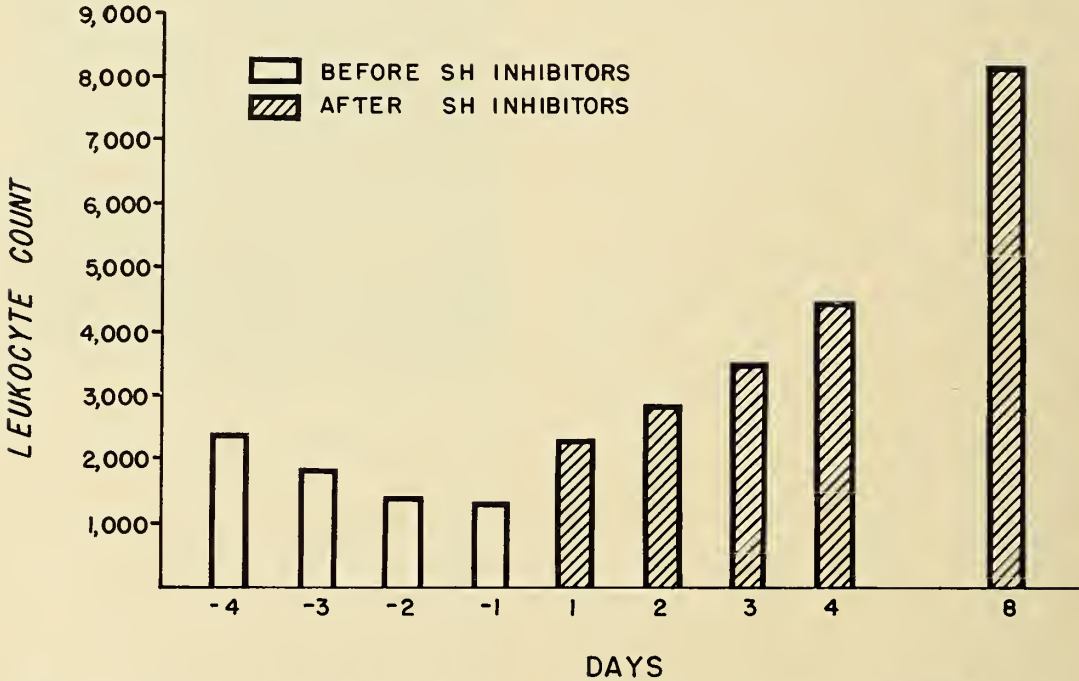


Fig. 2. Improvement in peripheral leukocyte count during chemotherapy with sulfhydryl inhibitor oxophenarsine plus adjuncts malonate, heparin and fluoride for a patient with disseminated adenocarcinoma of colon and with marrow depressed by prior treatment with 5-

fluorouracil and hydroxyurea. While her peripheral leukocyte count rose from 1250 to 4500 in four days, her platelet count improved from 27,000 to 365,000. The sulfhydryl inhibitors effected objective regression of her palpable tumor meanwhile of over 25 percent.

genase of 18. These fell to normal levels of 160.39 and 0, respectively, during chemotherapy. The patient is still counted as indeterminate for effects of chemotherapy because objective regression of cancer could not be palpated or measured.

Because the patient's cancer grew rapidly between admissions when she received no chemotherapy (as evident from the rise in enzyme values) she was discharged to her local physician on twice weekly injections of 5-fluorouracil at 7.5 to 10 mg/kg dose, depending upon her leukocyte count. At one year, the patient was doing well clinically.

When her tumor loses its sensitivity to 5-fluorouracil as it almost surely will, the plan is to readmit her for chemotherapy with newer sulfhydryl inhibitors⁸ to which her tumor is more sensitive by agar plate assays similar to figure 1.

Case 2. A 58-year-old woman was admitted with adenocarcinoma of the colon massively disseminated to liver and all abdominal organs and with marrow depressed

by prior treatment with 5-fluorouracil and hydroxyurea. Before treatment with oxophenarsine plus adjuncts to which her tumor was sensitive, her peripheral leukocyte count was 1250 and platelets 27,000. The patient was moribund, with daily fever to 104°. The improvement in her hematologic status during chemotherapy with the sulfhydryl inhibitors is shown in Fig. 2. For the time interval shown in Fig. 2, all other anticancer drugs were withdrawn. Chemotherapy with the sulfhydryl inhibitor oxophenarsine plus adjuncts effected objective regression of her cancer while her peripheral leukocyte count rose from 1250 to 4500 in four days and her platelet count from 27,000 to 365,000.

Case 3. A 53-year-old woman was admitted with adenocarcinoma of the breast widely disseminated to bone and with a platelet count of 11,000. Because her previous medications with androgen, corticoid and thyroid hormone appeared to make the patient feel better, all previous medications were continued at their same level. During



Fig. 3. Improvement in platelet count during chemotherapy with sulfhydryl inhibitor oxophenarsine plus adjuncts malonate, heparin and fluoride for a patient with adenocarcinoma of the breast disseminated to most of her bones.

All other medications were continued during chemotherapy with the sulfhydryl inhibitors. The patient's platelet count gradually improved from 11,000 to 98,000 over a period of four weeks.

chemotherapy with the sulfhydryl inhibitors, her platelet count gradually rose from 11,000 to 98,000 over four weeks, when she was discharged to the care of other physicians. Fig. 3 shows the rise in platelet count accompanying chemotherapy with sulfhydryl inhibitors.

Case 4. A 61-year-old man was admitted with a known diagnosis of highly anaplastic cancer in his left supraclavicular area from an unknown primary. Tumor in the same area had been resected by another surgeon six months earlier. Review of the slides showed an anaplastic tumor consistent with neurofibrosarcoma, angiosarcoma or anaplastic thyroid carcinoma. Extensive radiologic workup, including thyroid scan, revealed no primary. In addition to the tumor, the patient's main abnormality was a fibrinolysis of 65 percent (normal of 0-5%).

At surgery, tumor going down into the mediastinum was obvious. Chemical tests showed good sensitivity of the tumor especially to the sulfhydryl inhibitors, with newer drugs⁸ showing considerably greater activity than did currently available oxophenarsine plus adjuncts. Alkylating agents, especially chlorambucil, showed good activity and Actinomycin D (Dactinomycin) less activity, and hydroxyurea, none. During a three week course of chemotherapy with oxophenarsine plus adjuncts, the patient received also 3200 roentgens of radiation to the left supraclavicular area, as well as a course of three injections of autogenous vaccine.³

He was discharged on chlorambucil for maintenance chemotherapy daily. Ten months after discharge, he is clinically well and his fibrinolysis has returned to normal (4.6%). Hopefully, he will be maintained on available drugs until the new sulfhydryl inhibitors suitable for oral maintenance chemotherapy become available.⁸ His tumor is especially sensitive to pyruvaldehyde and its unstable adducts.⁸

Comment

Probably all four of the patients presented received benefit from chemotherapy with the sulfhydryl inhibitors. Three of the four patients (cases 1, 3, and 4) are counted as indeterminate for effects of chemotherapy, however, because such ef-

fects could not be defined rigidly. Only case 2, in which objective regression of bowel cancer of over 25 percent occurred during chemotherapy with the sulfhydryl inhibitors, is counted as any objective effect. Improvement in laboratory values is not counted as an objective effect of chemotherapy on the present program.

Discussion

Currently available sulfhydryl inhibitors must be given intravenously and cannot be used for maintenance chemotherapy. As a result, patients must be taken off the sulfhydryl inhibitors and given other types of drugs for maintenance chemotherapy which, by sensitivity tests, are not as active against their tumors as are the sulfhydryl inhibitors.

Fortunately, newer sulfhydryl inhibitors have now been developed which appear eminently useful for maintenance chemotherapy and for oral use.⁸ The tumors of all patients now operated on by the author are tested for sensitivities to the new drugs, so that improved chemotherapy can be given them as soon as it becomes available for clinical use.

Even with the "stopgap" sulfhydryl inhibitors, however, a larger significance for the work appears to have emerged. Proper sulfhydryl inhibitors have regressed a variety of human cancers without injury to wound healing or hematologic status, or with actual improvement in hematologic status, as seen in Fig. 2 and Fig. 3. Wounds and marrow contain rapidly proliferating normal cells. The regression of human cancers without injury to wound healing or hematologic status confirms the greater attack by sulfhydryl inhibitors on cancer cells relative to normal which has been seen also in hundreds of sensitivity tests.^{2, 6-8}

These data on human cancers recall the work of Szent-Györgyi on lower forms of life. Nobel Laureate Szent-Györgyi has found that proper sulfhydryl inhibitors preferentially inhibit cell division of a variety of lower forms, with apparently greater attack on cancer cells than normal.⁹ The tissue extract Retine, probably containing the sulfhydryl-inhibitor pyruvaldehyde as active component, may be a rather universal cell regulator. It is found from mushrooms to clams to human urine, now its main

source. Szent-Györgi has predicted that proper sulfhydryl inhibition may open the way to a specific cancer therapy.⁹

The main clinical target of the sulfhydryl inhibitors is the sulfhydryl-bearing residual protein of chromosomes. This is tightly bound to DNA and as essential for the structure of chromosomes as is DNA itself. From the data above, this chromosomal residual protein with its sulfhydryl groups, appears to play a major role in regulating genes.^{2, 6-8}

Involved chemical data are summarized elsewhere^{2, 6-8} but four main lines of evidence support this conclusion: 1. the preferential attack of proper sulfhydryl inhibitors on human cancers and cell division; 2. the apparent universality of the sulfhydryl-inhibiting Retine as a potential cell regulator;⁹ 3. the marked susceptibility of sulfhydryl to a vast array of carcinogens, susceptibility exceeding that of other regulators heretofore suggested, like histones; and 4. the appropriate chemical and biologic attributes of chromosomal residual protein, with its sulfhydryl groups.

Sulfhydryl-bearing chromosomal residual protein is present on competent DNA where histones are deficient and the main synthesis of RNA is believed to occur; is known to increase in normal growth and cancer; is appropriately sensitive to anti-cancer agents; may be the site of synthesis of nuclear proteins and may be formed directly on DNA template to insure its proper position on DNA, as required for a potentially regulatory protein.

In the framework of the 1965 Nobel Laureates, Jacob and Monod, on regulator, operator and structural genes, nothing is now known about the chemical nature of the protein regulators on genes. The data presented above, however, suggest that SH-bearing chromosomal residual protein may be the regulatory protein governing operator genes (and hence structural genes of operons) which reacts with chemicals coded by the regulator genes (such as Retine, perhaps) or which reacts clinically with proper sulfhydryl inhibitors active against the patient's own cancer cells.

The extreme reactivity of protein-sulfhydryl groups and their exquisite sensitivity to small changes in their own environment now provide the necessary chemical attri-

butes for fine control of genes by residual protein of chromosomes but also points of attack for an almost endless array of carcinogens like viruses, radiation and chemicals.

Derangements in the potentially regulatory SH-bearing residual protein, produced by mutations or action of carcinogens, would be expected to increase disorder and availability of crucial sulfhydryl groups for reaction with proper sulfhydryl inhibitors. Thereby the susceptibility of human cancers to attack by proper sulfhydryl inhibitors would exceed that of normal tissues, to confirm the effects noted clinically. In this preferential attack on human cancers by proper sulfhydryl inhibitors lies their clinical promise for cancer chemotherapy.

Summary-Abstract

In a series of over 60 patients, oxophenarsine plus adjuncts malonate, heparin and fluoride, has regressed a variety of human cancers without injury to normal wound healing or hematologic status, or with improvement in hematologic status. The preferential attack by proper sulfhydryl inhibitors on human cancers and cell division; the apparent universality of a sulfhydryl inhibitor like Retine as a potential cell regulator; the marked susceptibility of sulfhydryl to most known carcinogens; and the appropriate biologic and chemical characteristics of sulfhydryl-bearing chromosomal residual protein suggest that residual protein and its sulfhydryl groups may play a major role in regulating DNA.

Patients for this study were referred by Drs. Raymond Galt, Paul Holinger, Dino Maurisi, Joyce Schild, Burton Kilbourne, Walter Lawrence, Alfred Reschke, William Hayes, John Meyer, Geza de Takats, Ernest Feiler, John Reynolds, Vernon Guynn, Robert Overstreet, John Long, Francis Straus, Robert Jensik, Frank Milloy, and Carl Davis. This study was aided by grants from E. R. Squibb and Sons and the Knock Research Foundation.

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(Continued on page 228)

Review of Recent Changes In Anesthesiology

By MAX SADOVE, M.D. & HOWARD O. SCHECHTER, M.D.

During the past few years, there have been several significant advances in anesthesiology as well as a re-evaluation of old and perplexing problems. In order to discuss some of these concepts, we have organized this presentation into changes that have developed during the preoperative, operative, and postoperative periods.

THE PREOPERATIVE PERIOD

Recently, there has been a shift from the absolute dictum that the rauwolfia drugs must not be administered for a period of two weeks prior to surgery. However, this is still being done, if the surgical team feels that the hazard of an elevated blood pressure is not great. This implies that the patient has a "controlled hypertension."

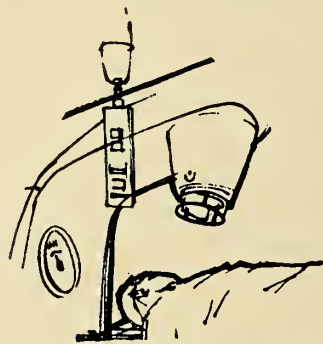
The study of this subject by E. M. Papper and his group at Columbia clearly explains why rauwolfia therapy is not a contraindication to general anesthesia. There is no doubt that hypertensive patients on drug therapy present an undetermined increased anesthetic risk. Prognostication of the degree of the risk is based upon the patient's symptomatology, electrocardiographic changes, fundoscopic changes, renal function studies, and other factors indicating the severity of the hypertensive disease state.

Modern Dosages of Rauwolfia

It has been conclusively shown that with the modern dosages of rauwolfia drugs used in hypertensive patients that catecholamines are rarely depleted from the body; although

this might not be true in psychiatric practice as the dosage is relatively large. At the University of Illinois Hospitals, we manage these patients by removing the drug for two weeks where possible, and if not possible, by treating significant hypotension (if it should occur) with vasopressors which act without depending on the release of catecholamines. At times, these patients are

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

treated with epinephrine for approximately one-half hour by infusing a dilute solution in a concentration sufficient to moderately raise the blood pressure.

There have been no significant alterations in the evaluation of the patient's physical status. Blood volume studies have been available for several years, although they have not been used as extensively as we have wished, but they are being used more each year. The value of a central venous pressure reading in the preoperative

From the department of anesthesiology, University of Illinois Research and Educational Hospitals and the departments of anesthesia, Veterans Administration, Hines and Westside VA Hospitals.

patient has been realized. Jacob Fine has recently demonstrated that blood volume studies are more accurate than C.V.P., but he does indicate that each technique has its own limitations. The central venous pressure catheter becomes very valuable where a large volume of fluid is used and where cardiac overload is a real problem. This is of particular importance in the patient with poor cardiac reserve and where vasodilators are used to treat shock.

Preoperative Inhalation Therapy

Unfortunately, preoperative inhalation therapy for patients with respiratory disease problems has not been used as frequently as we feel is necessary. Its value should be reassessed by those not actively employing it.

No major change has occurred in the use of ataratic drugs. There is a tendency to be fearful of the drugs which are sympatholytic. The hypotension and tachycardia are at times troublesome when one is not prepared for these events. However, propiomazine (1 to 2 mgm per 10 lbs. of lean body weight) (largon) has been used with increasing frequency because of its rapid onset of action, few undesirable side effects, and provision of excellent hypnosis and sedation i.e. "sleep state." Its effect is gone in approximately three hours. It is a very convenient drug for an "on call" medication. It is useful in the child or nervous adult, because the intramuscular injection works very rapidly to produce a desirable state; if it is used intravenously, its effects are clearly evident within 10 minutes. This makes it very useful for the crying child during the post-operative period. There is some interesting investigative work suggesting that this drug may also have an "anti-stress" factor similar to that of thorazine but milder in nature.

THE OPERATIVE PERIOD

When considering the changes which have occurred during the operative period, it can be said that there have been only a few significant changes in regional techniques. A new local anesthetic prilocaine has a greater margin of safety than lidocaine. As much as 900 mg (without epinephrine) has been given to man during various regional techniques without

causing symptoms of toxicity. Its effects last for approximately two and one-half hours. Our studies at the University of Illinois show that this drug can cause methemoglobinemia. It seems to occur in a direct dose response relationship. The intravenous administration of 2mg/kg of methylene blue will reverse this effect. Methemoglobinemia is of no clinical significance if the total dose of the drug is 500 mg or less.

There has also been the reintroduction and more adequate study of intravenous lidocaine (xylocaine) for surgical procedure of the upper and lower extremities. Basically, this consists of a maneuver to remove the blood from the arm or leg by an elastic bandage or gravity; then the placement of an obstructing tourniquet and finally the injection of a local anesthetic intravenously. Usually about 250-350 mg. of one-half percent solution is used, and it is left in the obstructed arm for about 20 minutes. This permits diffusion and fixation of the local anesthetic. When the tourniquet is released actual measurement of the concentration of local anesthetic in the blood has been found to be very low. A more peripheral tourniquet may be placed distal to the initial tourniquet to avoid pain from the initial obstructing tourniquet. The tourniquet should not be released for at least 20 minutes, after drug injection nor remain inflated longer than 90 minutes.

Intravenous Local Anesthetic

The use of the intravenous local anesthetic for basal anesthetic to supplement intravenous or inhalation anesthesia has remained popular primarily in the economically stressed areas of the world. In the United States it has been decreasing each year and is being replaced by drugs of the "tranquilizer type" in combination with narcotics.

Discussion of "Neurolept Analgesia" continues to appear in the literature with increasing frequency. One wonders if this is not essentially the same process (if not pharmacologically, at least clinically), as the "hibernation" introduced by Laborit. The "lytic cocktail" is really another form of neurolept anesthesia or analgesia. However, the drugs used to produce it now

are slightly different. This technique like the "lytic cocktail" depresses circulation slightly, does have antistress factor and is a basal type sedation of the central nervous system, and is probably a useful and safe technique. However, there is still ambiguity as to what is occurring scientifically. It seems that the essence of this technique is the relative sparing of the depression of the vital centers. This is being achieved with many agents now in our armamentarium but not labeled "Neurolept Analgesia."

Detoxification of Anesthetics

It has been taught that inhalation anesthetics are not detoxified (or metabolized) in the body. They were thought to be excreted through the respiratory tract unchanged. This concept has recently been restudied; preliminary data obtained by using radioactive isotopes show that all agents investigated undergo a small but significant amount of metabolic breakdown *in vivo*. It is too early to draw any clinical conclusions from this data; however, there is considerable attention being drawn to this area of investigation.

The halothane controversy is now over. The results of the National Halothane Study supported by the National Institute of General Medical Science were published in *JAMA*, Vol. 197, 775-788. A retrospective study was done to determine the incidence of fatal hepatic necrosis and overall death rate following general anesthesia. It was concluded that postoperative fatal hepatic necrosis was rare, and could usually be explained on the basis of circulatory shock, sepsis, or previous hepatic disease. "Halothane rather than being a dangerous anesthetic had a record of safety as reflected in an average mortality of 1.87% compared to an average for all anesthetic practices of 1.93%. No evidence was found to support the imputed risk of halothane in operations performed on the gallbladder or bile ducts." On the basis of this, this study and as the result of our clinical experience with this drug, we find no contraindication to its administration to patients with hepatic disease.

Methoxyflurane has been increasing in popularity as an agent for general anesthesia. However, we suggest its greatest sig-

nificance will be in the replacement of Trichlorethylene for obstetrical analgesia and for the very long case rather than the short procedure. Newer equipment of the "Fluotec" type has been made—the "Pentec" and another one by Forreger that may increase the use and the efficiency of one of this agent. Methoxyflurane's popularity is increasing in the very long case of requiring good relaxation.

SHOCK

The therapy of shock has continued to fluctuate, as it has done since the syndrome was first described. This year has seen the continued use of the corticoids with preference shifting away from cortisone to the drugs which have less water retention properties, and more to the drugs that are similar in action, but with more anti-stress properties. The use of these drugs is more frequent in temporary renal shutdown and toxic and hypoxic visceral injury. Data from the Vietnamese War zone is now questioning not the safety but the efficiency of steroids without the use of more of the important factors such as: fluid replacement, blood replacement, and maintaining metabolic balance.

Low molecular weight dextran has become available on a limited basis. Its initial studies encourage its usage because of its ability to alter peripheral resistance. The mechanism of the changed peripheral is not known. Its effect upon the kidney and the micro-circulation is encouraging. The central venous pressure is very helpful if one is to avoid circulatory overload. Dibenzyline still is in the realm of an experimental agent. Its place in the treatment of shock is still awaiting the accumulation of more data before it can be fully evaluated. Other blocking agents which have a similar effect, such as chlorpromazine, are now being used clinically.

Intravenous in Intraoperative Period

There has been a radical change in fluid therapy (intravenous) in the intraoperative period. We have all been taught that there is a postoperative oliguria with a relative hypernatremia—this was explained on the basis of "stress adaptation" and consequent hypersecretion of corticosteroids. Shire from Dallas, Tex., has

proven, via triple isotope studies, that there is a shift of the intravascular fluids to the extracellular space during intra-abdominal and intrathoracic procedures. He found that this loss could be compensated by infusing 4-10cc/kg hour of ringer's lactate solution. He then observed that the patient's operative course was more stable. There was a decreased need for blood transfusion and there was no postoperative oliguria in the past was because the patient was "dehydrated." We have adopted this technique of fluid therapy and we agree with Shire's observation. However, we have recently seen a few patients with impending congestive heart failure in the post-operative period. We are presently investigating these specific cases. However, his basic promise is a sound one and must be carefully examined and utilized where logical.

Hypothermia and Hypotension

The classical concept of hypothermia and hypotension alone and in combination are diminishing in their frequency of utilization. We feel that at times these techniques work to the detriment of the patient. Hypotension of a moderate type is being utilized more frequently in a rather insidious manner especially with drugs such as fluothane. The advantage of the drug halothane is the ease with which the hypotensive state may be created, controlled or terminated. Prerequisites for this technique are an adequate total circulatory volume, a constant intravenous infusion to maintain volume, and means whereby the hypotension may be evaluated and distinguished from the true micro-circulatory stagnancy. The electroencephalograph, electrocardiograph and central venous pressure catheters are important factors in utilization of this technique combined with careful clinical observation of the patient. It has become increasingly obvious to all trained anesthesiologists that hypertension is not "shock" and that elective hypotension is an entirely different process than uncontrolled hypotension. Parallel to the anesthesiologist's considerations of the very vital factor of microcirculation is his general condemnation of the utilization of certain

vasopressors with the concomitant development of acidosis and diminished tissue perfusion. The problem of tissue acidosis has in the last year occupied an increasing interest on the part of the anesthesiologist. The availability of the micro-astrup instrumentation has played a vital role in the ease and speed with which blood oxygen tension, pH, pco₂, pCO₂ and buffer base have been determined.

Hypothermia in Postcardiac Arrest

Hypothermia is still being utilized in the postcardiac arrest therapy and at times in operative procedures in which major vessels have been temporarily occluded. There is no doubt that hypothermia is a definite protective factor when tissues are exposed to a hypoxic environment. Experience with this technique will continue to accumulate, especially in operations of the transplant type. We have continued to utilize hypothermia for the extensive eviscerative type procedures and for those procedures in which blood flow is interrupted for variable periods of time. Yet to be answered is the question as to whether or not low molecular weight dextran is an ideal agent to add to this technique.

This year has seen the popularity of many pieces of disposable equipment in the operating room such as: catheters for suction, plastic tubing, spinal anesthesia trays, warming coils, paper surgical drapes, single use needles, and single use syringes. In general this equipment provides increased safety and increased efficiency. However, equipment such as the spinal tray must wait a longer period of time for evaluation to be sure that the sterility factor is satisfactory. The possibility of a minute puncture of the spinal tray and its subsequent contamination is a frightening thought. Studies up to this time indicate that this equipment is safe!

Obstetrical Anesthesia

In obstetrical anesthesia one of the major changes has been an increase in the number of people concerned about the perinatal mortality, there is a great emphasis on the teaching and training of personnel relative to resuscitation of the depressed new-born. There has also been an attempt by official bodies, particularly the

American Society of Anesthesiology, to standardize the dosage of local anesthetics used in spinal anesthesia. The epidural anesthetic is still popular with those who have taken the time to learn its technique. This past year saw an increase in the interest of trans-vaginal paracervical pudendal block and the introduction of a continuous paracervical pudendal catheter to simplify easing administration of the anesthetic. This technique must await a longer period of time for final evaluation. It still remains a question in the minds of some as to how much of the anesthetic in the paracervical technique finally gets into the fetal circulation.

The catheter modification of the paracervical block also increases the safety. With this technique, one can give minimal dosage and repeat the dosage of local anesthesia as needed, thus avoiding to a great extent the hazards of reactions to local anesthetics that are inherent to many of the techniques now used in obstetrics. This is especially true because the duration of anesthesia for labor is not the same for every patient.

Muscle Relaxant Drugs

The use of muscle relaxant drugs has increased in usage. They are being utilized in conjunction with lighter and lighter stages of anesthesia to avoid the undesirable side action of deep anesthesia. It was previously thought that succinyl choline caused a depolarizing block in low doses and in higher doses caused a dual block. The recent literature indicates that with low dosage and continued administration, there is a diphasic block. We have confirmed the diphasic type of blockade with relatively small doses of succinyl choline. It implies that when using succinyl choline (which was believed to have its effect terminated rapidly), one must be cautious to watch for "residual curarization." The question of pharmacologic reversal of the dual blockade seen with succinyl choline is open for discussion. It should only be used after a dual block has been established with a blockade monitor or by the use of Edrophonium and other Anticholinesterase agents.

During the last few years, there has been increasing popularization in the use of

respirators in the preoperative and postoperative periods. The increased knowledge concerning defusion block and miliary atelectasis has led to the use of respirators with the interrupters that simulate a sigh or deep breath at varying intervals. The important factor in the increased use of these instruments has been the further training of the inhalation therapist who has helped in the management of this equipment. However, there is a lag in availability of trained personnel. There has been a failure to keep pace in the training of nurses in the care of patients using this type of equipment. There has also been the development of various automatic alarms so that if a respirator fails to cycle properly or the cycle is interrupted for a period of approximately 10 seconds, an alarm rings.

POST OPERATIVE PERIOD

In the postoperative period one must re-evaluate his method of administering aerosol therapy. The bubble oxygenator has largely been abandoned and rightfully so. It has also been proved that the nebulizer devices do not add the necessary amount of moisture to the inhaled gases. This year saw the greater utilization of the ultrasonic generators. They have a more uniform particle size which is approximately three microns in diameter, a greater density of fluid, i.e., more cubic centimeters of liquid per unit volume of gases inhaled. This presents a potential problem in the newborn and small infant. One must be careful to avoid fluid overload. The best vehicle for aerosol therapy is one half to one quarter strength saline, in contrast to 0.9 percent saline. The aforementioned fluids are not irritation to the respiratory tree. Again, one must be prudent in administering a salt solution to a newborn as they are unable to excrete salt as well as the adult.

We have previously described atelectasis as being fever, tachycardia, hemogenous densities seen in the chest x-ray, narrowing of the rib interspaces, elevation of diaphragm and shift of the heart to the side of atelectasis. We now know that atelectasis (miliary) may appear without these classical signs. In general this diagnosis is made when we find a decreased arterial pO_2 without evidence of hypoventilation or a "diffusion block." It is often difficult to

separate this syndrome from a physiologic shunt and perhaps it may be just a continuance of this mechanism. The old technique for postoperative respiratory care was deep breathing and coughing. We did not know why it benefited the patient and we postulated that its positive effect was because it helped the body rid secretions which caused bronchiolar plugs. We now believe this therapy is still of significant value, the mechanism of its effect is due to its expanding collapsed or partially collapsed alveoli with the improvement of ventilation perfusion ratio. As mentioned, the diagnosis of miliary atelectasis can only be made with accuracy when one does arterial blood gas analysis. We have done over 3000 arterial punctures (radical or brachial arteries) using number 25 gauge needles without any serious complications. In patients who are critically ill, we often insert an arterial catheter in order to obtain blood samples without subjecting the patient to multiple needle punctures. We have found that by early detection of altered ventilation perfusion ratios by laboratory methods that we have prevented many cases of "classical atelectasis" from occurring by instituting early therapy.

Electronic Monitoring Equipment

This year saw greater utilization of electronic monitoring equipment. It is our personal view that the equipment is still in the developmental stage. There are good cardioscopes, electroencephalograms, peripheral pulse detectors, and servo-mechanisms for alarms; however, these machines fail to measure the early physiologic changes in abnormal states. This year saw the acceptance of the D.C. defibrillator and rejection of the A.C. defibrillator. We are beginning to see the first stages of the logical approach to monitoring of the cardio-respiratory systems. However, the critical component of these mechanical devices is still in embryonic phase.

The recovery room and intensive care unit concept continue to expand. There have been many advances in the physical plant and equipment areas such as: wall oxygen, compressed air, and vacuum (limited, non limited and intermittent), intercoms, alarm systems, and monitoring de-

vices similar to those in the recovery room. However, the use of these facilities for significant research, training and teaching have lagged behind the physical advances. We predict the concept of the intensive care units will expand with cardiac units, stroke units, etc. as the increasing influence of government sponsorship is felt.

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INSURANCE FORM CHANGED ◇ ◇ ◇ ◇ ◇ ◇

Two changes have been made in the Health Insurance Claim form (Comb-1) approved for physician use by ISMS, AMA and the Health Insurance Council.

The form stipulates that the patient is financially responsible for any charges not covered by his insurance. It provides space for the patient to authorize direct payment of his insurance benefits if his doctor is willing to accept an assignment.

The second change provides space for authorization by the patient to the physician to "release any information acquired in the course" of the doctor's examination or treatment.

All Illinois physicians have been urged by the ISMS House of Delegates to use the Comb-1 form when dealing with private insurance claims. The House has recommended these procedures:

Complete and return to the insurance company any claim form bearing the Health Insurance Council symbol.

When a form not identified by the HIC symbol is received, the physician should complete the Comb-1 form, clip it to the unacceptable form, and return both to the insurance company.

Form shown on page 205 is available in quantity from the Division of Public Relations and Economics, Illinois State Medical Society, 360 N. Michigan Ave., Chicago 60601.

Tension

(Continued from page 183)

that are too often a part of modern living. However, tension is not bad if handled properly. Too much basic security would result in a cow-like state. There would be no drive to achieve success. If we all could be given this information as soon as we could understand it, we would avoid a lot of needless concern over our normal body reactions and, therefore, not become a prey of our tensions. We could then utilize the extra force we get from tension without permitting it to disturb our body function.

Following the presentation the patients are then told that we cannot change the reaction which is already present; however, if the patients understand that certain situations will produce certain symptoms they can then take steps to avoid getting into a vicious circle whereby the situation causes symptoms which in turn then produce a fear reaction which in turn causes more symptoms. In most cases the patients show some understanding following exposure to this lecture. Very often they will say that they understand this already but that they have never been able to relate this to their

own symptoms. Previous knowledge obtained through the family history can be brought forth at this time to demonstrate why patients have insecurity problems. This often is not necessary, however, because the patients may relate this verbally or will retain the knowledge for their own use. It is not possible to give an accurate statistical analysis of the results of exposure to the presentation.

There are too many factors which might enter here concerning good results. Obviously being told by a physician after a complete workup there is no organic illness will often do much to relieve a tension state. Nevertheless, it is my distinct impression that many patients who have had previous workups without exposure to the presentation gained distinct benefit after it was given. Incidentally, at the present time this presentation is being made use of in several high schools for the purpose of exposing the seniors to the knowledge given in the lecture. This is with the thought of prophylaxis. It is hoped that by showing the senior high school students that various symptoms may occur following exposure to certain situations that definite tension diseases may be prevented.

ATTENDING PHYSICIAN'S STATEMENT — HEALTH INSURANCE CLAIM — GROUP OR INDIVIDUAL

COMB-1 1964

Spaced for Typewriter — Marks for Tabulator Appear on this Line

PATIENT'S NAME AND ADDRESS

AGE

INSURED'S NAME IF PATIENT IS A DEPENDENT

NAME OF INSURANCE COMPANY

POLICY NUMBER

IF GROUP INSURANCE GIVE NAME OF POLICYHOLDER
(i.e., Employer, Union or Association through whom insured)

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

DATE 19

SIGNED (PATIENT, OR PARENT IF MINOR)

AUTHORIZATION TO PAY: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS SERVICES AS DESCRIBED BELOW BUT NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGE FOR THESE SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY THIS AUTHORIZATION.

DATE 19

SIGNED (INSURED PERSON)

(1A) DIAGNOSIS AND CONCURRENT CONDITIONS
(IF FRACTURE OR DISLOCATION, DESCRIBE NATURE AND LOCATION)(B) IS CONDITION DUE TO INJURY OR SICKNESS
ARISING OUT OF PATIENT'S EMPLOYMENT? IF "YES" EXPLAINYES ☐ NO ☐(C) IS CONDITION DUE
TO PREGNANCY?IF "YES" WHEN AND WHERE APPROXIMATE DATE
OF COMMENCEMENT OF PREGNANCY?YES ☐ NO ☐

DATE

19

(2A) WHEN DID SYMPTOMS FIRST APPEAR

DATE 19

(B) WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?

DATE 19

(C) HAS PATIENT EVER HAD SAME
OR SIMILAR CONDITION? IF "YES" STATE WHEN AND DESCRIBEYES ☐ NO ☐(3A) NATURE OF SURGICAL OR OBSTETRICAL
PROCEDURE, IF ANY (Describe Fully)(B) CHARGE TO PATIENT FOR SURGICAL
INCLUDING POST-OPERATIVE CARE

DATE 19

(C) IF PERFORMED IN HOSPITAL, GIVE NAME OF HOSPITAL

INPATIENT ☐ OUTPATIENT ☐(4) GIVE DATES OF OTHER MEDICAL (NON-SURGICAL)
TREATMENT, IF ANY

CHARGE PER CALL

OFFICE \$

HOME \$

HOSPITAL \$

NURSING HOME \$

TOTAL (NON-SURGICAL) CHARGES \$

(5) WHAT OTHER SERVICES, IF ANY,
DID YOU PROVIDE PATIENT?
(ITEMIZE, GIVING DATES AND FEES)(6) WERE REGISTERED PRIVATE DUTY NURSE (R.N.)
SERVICES NECESSARY?YES ☐ NO ☐(7) IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
IF "NO" GIVE DATE YOUR SERVICES TERMINATEDYES ☐ NO ☐

DATE

19

(8A) HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY
TOTALLY DISABLED (Unable to work)?

FROM 19 THRU 19

(B) HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?

FROM 19 THRU 19

(C) WAS HOUSE CONFINEMENT NECESSARY? IF "YES" GIVE DATES

YES ☐ NO ☐

FROM 19 THRU 19

(9) TO YOUR KNOWLEDGE DOES PATIENT HAVE OTHER HEALTH
INSURANCE OR HEALTH PLAN COVERAGE? IF "YES" IDENTIFYYES ☐ NO ☐

DATE

SIGNATURE (ATTENDING PHYSICIAN)

DEGREE

TELEPHONE

STREET ADDRESS

CITY OR TOWN

STATE OR PROVINCE

ZIP CODE



MEMORANDUM REGARDING DISPOSITION OF THIS FORM ON REVERSE SIDE

Approved by Council on Medical Service, AMA November 1964



MAN, A FERTILE ANIMAL

Many authorities believe birth control is the answer to the wide world population explosion. If you try to raise a country's income per head, you can do a hundred times more with a dollar spent on retarding population growth than on accelerating economic output. President Johnson said that less than \$5 invested in population control is worth \$100 invested in economic growth. This is true especially in the underdeveloped countries of the world where we have now made it possible for them to combine a medieval birth rate with a twentieth century death rate.

Advances in science and technology will not deliver these people from poverty. They not only need food now but also additional clothes, houses, hospitals, and education. The latter is important because an enlarging population needs brains to obtain the prosperity that comes from industrialization. Meanwhile the population tide continues.

Times are changing and what was right in the old world may be wrong in the new. Some factions believe that fertility is the last thing that should be controlled. A population consists of the individuals and whether they should have babies is very

much their own affairs. On the other hand, we should not withhold knowledge on birth control. In the past, survival of the race depended upon most women having babies over and over again. The situation has changed and women should know how to avoid unwanted pregnancies in order to improve the status quo of the living. Contraception is not natural; nor is penicillin to stop the mother dying of infection.

The alternative to reducing the birth rate is to increase the death-rate. Throughout the ages birth has been synonymous with good, but death with bad. Man still does his utmost to interfere with nature when human life is in danger. To increase the death rate means going back a century and discouraging medical progress and advances in public health. It means more wars and pestilence. Fathers would also bury many of their babies instead of bringing them up as they do now.

It took hundreds of thousands of years to reach our present population of 3400 million men, women, and children. If population continues unchecked a second million will be added in only 35 years.

T. R. Van Dellen, M.D.



THE VIEW BOX



Fig. 1

By LEON LOVE, M.D.
DIRECTOR, DIAGNOSTIC RADIOLOGY
COOK COUNTY HOSPITAL

This five year old mentally deficient male child entered the hospital after his mother noted a hard mass in his upper abdomen. He had complained to her about "a stomach ache." She recalled that he had vomited several times in the last four months. Physical examination revealed a palpable mass in the upper abdomen which the examiner thought he could move about on pressure. An I.V.P. was done.

What's your diagnosis?

1. Cancer of the stomach.
2. Neuroblastoma.
3. Bezoar of the stomach.

(See answer on page 210)



Tofrānil® imipramine hydrochloride

Brief Summary: Tofrānil produces remission of symptoms in about 3 out of 4 patients with endogenous and reactive depressions.

Contraindications: Do not use drugs of the M.A.O.I. class with Tofrānil. Hyperpyretic crises, severe convulsive seizures and potentiation of adverse effects can be serious or even fatal. When substituting Tofrānil in patients receiving an M.A.O.I. agent, allow an interval of at least 7 days. Tofrānil dosage in such patients should be low and increases should be gradual and cautiously prescribed.

Warning: Reports have suggested there may be a risk of teratogenesis with this drug during the first trimester of pregnancy. Use low dosage and care in patients with cardiovascular disease. Cardiovascular complications, including myocardial infarction and arrhythmias, have occurred.

Precautions: Do not rely on this drug to remove the threat of suicide in seriously depressed patients. Administer cautiously to patients with increased intraocular pressure, and to hyperthyroid or thyroid-treated patients.

Adverse Reactions: Dryness of the mouth, tachycardia, constipation, disturbances of accommodation, sweating, dizziness, weight gain, urinary frequency

or retention, nausea and vomiting, peripheral neuritis, mild parkinson-like syndrome, tremors, rare cases of falling in elderly patients, agitation (including hypomanic or manic episodes), confusional states (with such symptoms as hallucinations and disorientation), activation of psychosis in schizophrenics, epileptiform seizures, orthostatic hypotension and substantial blood pressure fall in hypertensive patients, purpura, transient jaundice, bone marrow depression including agranulocytosis, sensitization and skin rash including photosensitization, eosinophilia, and mild withdrawal symptoms on sudden discontinuation after prolonged treatment with high doses. Occasional hormonal effects (impotence, decreased libido) and estrogenic effects may be observed. Atropine-like effects may be more pronounced in susceptible patients and in those using anticholinergic agents.

Average Adult Dosage: Initially, one 25 mg. tablet t.i.d., increased to two 25 mg. tablets t.i.d. or q.i.d., if necessary. Maintenance therapy and dosage for adolescent and geriatric patients should be lower. Not recommended for use in children under 12 years of age.

Availability: Round tablets of 25 mg., triangular tablets of 10 mg. for geriatric use, and ampuls, each containing 25 mg. in 2 cc., for I.M. administration.

See Prescribing Information for full details.
6565-VIII(B)R

Geigy Pharmaceuticals
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When a milestone in life is
marred by depression...

In almost 3 out of 4 cases,
such symptoms of depression
as feelings of insecurity,
distrust, sadness, and hope-
lessness will respond to
Tofrānil therapy.

Tofrānil[®] imipramine
hydrochloride

Geigy



Robert L. Richards (center) displaying plaque presented to him during the January meeting of the ISMS Board of Trustees. Recognizing Richards' six years of service to the society, the plaque was presented by Arthur F. Good-year, M.D., (left) board chairman, and Caesar Portes, M.D., president.

— THE VIEW BOX —

DIAGNOSIS AND DISCUSSION

(Continued from page 207)

DIAGNOSIS: Bezoar of the stomach.

The I.V.P. reveals normal renal collecting systems. A foreign body is outlined by gas within the stomach. It was then noted that the child had bald areas of his scalp. A nurse on the ward observed him pulling the hair out of his head and eating it.

Trichobezoar or hair ball comprises 55 percent of reported cases of bezoar. Phytobezoars are composed of vegetable fibers such as celery, persimmon seeds, prunes, plums and raisins. Clinically the occurrence of abdominal pain, a fully moveable upper abdominal mass (which has a mottled appearance on administration of barium) help to make the diagnosis. For some unexplained reason the foreign body remains in the stomach even when small, and only very occasionally will it cause small bowel obstruction. Hemorrhage can be a serious complication. The patient required a gastrotomy for removal of the hair ball.

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Allergy

(Continued from page 191)

ly otherwise. They are probably non-allergic and can be managed with antihistamines if any treatment is necessary. At least one antihistamine combination (Ornade) contains iodine and is best avoided. Skin testing and allergic managements are not indicated.

One last concluding remark—the basic management of the allergic woman is no different when she is pregnant than when she is not. If she is cat-sensitive, she should avoid cats; and if she is allergic to feathers, she should not sleep on a feather pillow. Avoidance of the underlying cause of her allergy may well be the key to success in making her pregnancy a happy one.

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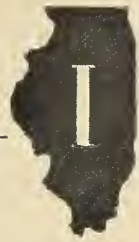
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Air Pollution Control

The State of Illinois has been cited by the U. S. Public Health Service for its work in controlling air pollution, according to Dr. Franklin D. Yoder, director of the Illinois Department of Public Health.

The citation commends the state's participation in the National Air Sampling Network.

NEWS and ANNOUNCEMENTS



Crippled Children's Clinics

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The division will conduct 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- March 1, Carmi—Carmi Township Hospital
- March 1, Hinsdale—Hinsdale Sanitarium
- March 2, Effingham General—St. Anthony Memorial Hospital
- March 2, Peoria Cerebral Palsy (A.M.)—Roosevelt School
- March 2, Sterling—Community General Hospital
- March 7, Carrollton—Boyd Memorial Hospital
- March 8, Champaign-Urbana—McKinley Hospital
- March 8, Joliet—Silver Cross Hospital
- March 9, Springfield General—St. John's Hospital
- March 10, Chicago Heights Cardiac—St. James Hospital
- March 14, East St. Louis—Christian Welfare Hospital
- March 14, Peoria General—Children's Hospital
- March 15, Jacksonville—Passavant Memorial Hospital
- March 15, Evergreen Park—Little Company of Mary Hospital
- March -15, Rockford—St. Anthony's Hospital
- March 16, Decatur—Decatur & Macon Co. Hospital

- March 16, Sparta—Sparta Community Hospital
- March 16, Elmhurst Cardiac—Memorial Hospital of DuPage County
- March 21, Alton General—Alton Memorial Hospital
- March 22, Centralia—St. Mary's Hospital
- March 22, Elgin—Sherman Hospital
- March 23, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital
- March 24, Chicago Heights Cardiac—St. James Hospital
- March 28, Belleville—St. Elizabeth's Hospital
- March 28, Danville—Lake View Hospital
- March 28, Peoria General—Children's Hospital
- March 29, Springfield Cerebral Palsy (P.M.)—Clinic site to be announced

Meetings

Feb. 21—Mark M. Ravitch, M.D., professor of surgery and pediatric surgery and head of the division of pediatric surgery at the University of Chicago, will speak on "Congenital Deformities of the Chest Amenable to Surgical Treatment" at a dinner meeting of the Chicago Pediatric Society. Reception is scheduled for 6 p.m., dinner at 7 p.m., and meeting at 8 p.m. in the Walton Room of the Drake Hotel, Chicago.



Feb. 24—"Chemotherapy of Cancer," eighth in a series of weekly lectures presented at the University of Chicago by the nation's leading cancer researchers. Dr. Anthony R. Curreri, professor of surgery and director of the division of clinical oncology at the University of Wisconsin, will speak at 5 p.m. in Room P-117 of Billings Hospital, 950 E. 59th St., Chicago. Concluding the series are:

Mar. 3—"Recent Advances in the Treatment of Leukemia" by Dr. Henry S. Kaplan, professor and executive, department of radiology, Stanford University School of Medicine.

(Continued on page 253)

starts fast...
keeps going...
relieves pain...

effective pain relief within 15 minutes...lasts 6 hours or more

 PERCODAN relieves pain fast—usually within 15 minutes—and for prolonged periods, usually for 6 hours or more. Further, its speed and potency are *predictable* in the wide middle range of pain.  PERCODAN is well tolerated and rarely causes constipation. **Usual Adult Dose:** 1 tablet every 6 hours. **Precautions:** The habit-forming potentialities of Percodan are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although

generally well tolerated, Percodan may cause nausea, emesis or constipation in some patients. Percodan should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. *Literature on request.*

PERCODAN[®]

Each scored yellow Percodan Tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine. U. S. Pats. 2,628,185 and 2,907,768

ENDO LABORATORIES INC., Garden City, New York



Endo[®]

Safety of Symmetrel® Confirmed. When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Prescribing Information

Indications: "Symmetrel" is indicated for the prevention (prophylaxis) of influenza A₂ in persons of all age groups. Early use is recommended, preferably before or as soon as possible after actual or suspected contact with individuals suffering from influenza A₂. "Symmetrel" should especially be considered for high influenza-risk patient groups such as those suffering from chronic debilitating diseases and elderly persons.

Contraindications: Not indicated for the prevention of influenzal or respiratory illness other than influenza A₂ or for the treatment of established disease.

Warnings: Administration to patients with central nervous system disease, particularly geriatric patients with cerebral arteriosclerosis, and patients with a history of epilepsy or other "seizures," requires strict observation for possible untoward effects (see Adverse Reactions). Patients taking psychopharmacologic drugs, central nervous system stimulants, or alcoholic beverages should be observed for possible evidence of intolerance. Those patients who experience central nervous system effects or blurring of vision should be cautioned against driving or working in situations where alertness is important.

No teratogenic effects have been seen in reproductive studies in rats and rabbits. Studies in pregnant women have, however, not been done and use of this drug in women of childbearing age should be undertaken only after weighing the possible risks to the fetus against benefit to the pregnant patient. It should not be administered to nursing mothers since it is not known whether the drug is secreted in the milk.

Precautions: Ineffective against bacterial infections. Patients should be observed for idiosyncratic reactions as with all new drugs. Geriatric patients with pre-existing serious medical illnesses with mental or physical deterioration should be followed carefully medically while taking "Symmetrel." (See Adverse Reactions.)

Adverse Reactions: With higher than indicated doses manifestations of central nervous system effects such

as nervousness, insomnia, dizziness, lightheadedness, drunken feeling, slurred speech, ataxia, inability to concentrate and some psychic reactions including depression and feelings of detachment were seen. Occasional blurred vision was reported at higher doses. Some of the milder and less pronounced symptoms above have been reported in a small number of patients taking the recommended dosage of 200 mg per day. Those were mostly transient and disappeared with continued administration of the drug. Some geriatric patients developed paranoid or hallucinatory behavior and became unmanageable while taking 200 mg daily. Medically unselected seriously deteriorated geriatric patients showed poor clinical tolerance after several weeks of daily dosing with 200 mg per day. One elderly patient with a history of prior cerebrovascular accident developed visual hallucinations and grand-mal convulsions while on drug at 800 mg per day. Some cases of dry mouth, gastrointestinal upset and skin rash and rarely, tremors, anorexia, pollakiuria, and nocturia have been also reported.

Safety: When used as indicated, is generally well tolerated. No kidney, liver, bone marrow, or hematological disturbances have been observed.

Dosage: Adults: Two 100 mg capsules (or 4 teaspoonfuls of syrup) as a single daily dose or the daily dose may be divided into one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

Children: 1 yr.—9 yrs. of age: Calculate total daily dose on the basis of 2 mg to 4 mg per pound of body weight per day (but not to exceed 150 mg per day). Daily dose, given as the syrup, should be given in 2 or 3 equal portions.

9 yrs.—12 yrs. of age: Total daily dose 200 mg given as one capsule of 100 mg (or 2 teaspoonfuls of syrup) twice a day.

How Supplied: Capsules: Bottles of 100. Each red, gelatin capsule contains 100 mg amantadine HCl.

Syrup: Bottles of 1 pint. Each 5 ml (1 teaspoonful) contains 50 mg amantadine HCl.



Symmetrel®
(Amantadine HCl)

A molecular barrier to virus penetration

EARLY AMERICAN APOTHECARY DEDICATED



Attending the opening of the International College of Surgeons' Early American Apothecary were (from the left) Dr. Samuel L. Andelman, Commissioner of Health, Chicago Board of Health; Charles R. Walgreen, Jr., member of the board of the American Institute of the History of Pharmacy; Anthony W. Ormiston, chairman of the board of directors, Surgeons' Hall of Fame; Dr. Herbert Pollack, chairman, exhibits committee, Surgeons' Hall of Fame; Maurice E. Miller, and Mrs. Miller, Ithaca, N. Y., and Lee Alport, director of Mel-Park Drugs, Melrose Park.

All the nostalgic charm of an early American apothecary has been brought to life with the opening of an 1873 drugstore in the Hall of Fame Museum of the International College of Surgeons, 1524 N. Lake Shore Dr., Chicago.

Authentic in every fascinating detail—even to the pungent aroma of an old-time pharmacy—the full-scale apothecary captures the atmosphere of a by-gone era.

It marks a significant historical contribution in preserving this phase of American culture. For the entire pharmacy, from authentic fixtures and original merchandise to apothecary equipment and prescription records, is composed of an actual apothecary that served its community in the 1873 era. Fixtures, equipment and merchandise from it were transported practically intact to Chicago.

Back in the prescription laboratory stands a "pharmacist" in clothes of the era, studying his record book which bulges with prescriptions filled long ago. Clustered around him are hundreds of pharmaceuticals on shelves and in a myriad of drawers labeled from Althea and Absinth to Indigo and G. Tragac. The drugs, some almost 100 years old, are still identifiable with their pungent odor contributing to the pharmacy's atmosphere.

In addition, the pharmacy carries other merchandise of the day—children's toys and schoolbooks, stationery, violin strings, and

Eastman Kodak products including an early box camera and film.

Resplendent along one shelf is a display of early decorative oil lamps which are now collectors' treasures.

From the old-fashioned charm of its paned-glass store front to the authentic prescription labels in the pharmacist's cabinet, the Early American Apothecary of the International College of Surgeons is a fascinating record of a vital American heritage.

President's Page

(Continued from page 140)

out us there is no AMA. Without us there is no Illinois State Medical Society. We are the backbone of medicine. We must be the backbone by our interest, by our participation.

I hope and pray that in this new year the Lord will give us the guidance which we need in our daily care of our sick people. That we will find wisdom in Him in our dealings with the government, with our fellow man. That He will bless us with good health and give us strength to carry on the morals, the principles, the ethics of the medical profession and that He will give us the power to be able to heal the sick and prevent disease, save lives and make life easier for those who are ridden with disease. May the Lord bless us all with His greatest blessings: Peace, peace of heart, peace of mind, peace to all mankind.

CAESAR PORTES, M.D.



**HOLY
FLABBERGAST-
IT'S
FATMAN!**

Being fat is no joke, of course. Certainly not to the obese patient—or to the physician concerned with the potential threat to the patient's health. In the serious matter of controlling weight through reduced food intake, Obedrin-LA tablets can be very helpful. Administered as directed, they trickle-release active medications in a balanced ratio to curb appetite, supplement restricted diet, sustain mood and allay anxiety

without undesirable side effects.

DOSAGE: 1 tablet daily, usually at 10 a.m.

SUPPLIED: Bottles of 50 and 250 on prescription only.

CAUTION: Obedrin-LA should not be given concurrently with monoamine oxidase inhibitors. It should be used with caution in patients having a sensitivity to sympathomi-

metic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution in pregnant patients, especially in the first trimester.

Obedrin®-LA*
"TRICKLE-RELEASE" TABLETS

Each tablet contains: Methamphetamine HCl*, 12.5 mg.; Pentobarbital*, 50 mg. (Barbituric Acid derivative; Warning: May be habit forming), Ascorbic Acid, 200 mg.; Thiamine Mononitrate, 1 mg.; Riboflavin, 2 mg.; Niacin, 10 mg.
*U.S. Pat. Nos. 2,736,682; 2,809,916; 2,809,917; 2,809,918 and pat. pend.

Usual and Customary Fees (Continued from page 163)

Public Aid Department for their usual and customary fee only. To do otherwise—to exceed the fees which you have normally charged—can only mean failure of the program and the eventual return of a fee schedule.

Some doctors may ask, "What is the usual and customary fee for a certain procedure?" They have their answer in their ledger books. The fee is that fee they have been charging for that particular procedure.

We anticipate that most physicians billing their usual and customary fee will be paid in full. We also anticipate that it will be necessary to adjust some billings to conform with both the ISMS and the Department of Public Aid's concept of "reasonableness." Provision has been made for the review of any fee adjustments by an appropriate committee at the request of either a physician or the Department of Public Aid.

There is another area in which your co-

operation is needed, and that is in the mechanics of billing. It is important that each procedure for which you bill be identified on your statement by the code number which has been assigned to it in *Current Procedural Terminology*. This guidebook is available at \$2 a copy (\$1 a copy for bulk orders of 25 or more) from the American Medical Association, 535 N. Dearborn St., Chicago 60610.

Of course, a physician is free to choose whether he will participate in the new public aid program. Any doctor who sees merit in this plan may participate simply by agreeing to accept as full payment that amount which is determined to be reasonable for the procedure performed.

It is certainly the hope of the Committee on Usual and Customary Fees that this program will make available to all the people of Illinois the services of all the doctors of Illinois. This is the goal toward which both ISMS and the Department of Public Aid have been working.



Togetherness....

...can be rough when epidemics of nausea and vomiting strike a family. Emetrol offers prompt, safe relief. It is free from toxicity¹ or side effects^{2,3} and will not mask symptoms of serious organic disorders.

1. Bradley, J. E., *et al.*: J. Pediat. 38:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. 20:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

Emetrol®
phosphorated carbohydrate
solution
emesis control

special formula for a special problem

*specifically formulated
for symptomatic
relief of sinus headache*

Sinus headache is not a single entity, but a chain reaction of pain. It is facial pain—deep, dull, aching and nonpulsating. It is referred pain—originating in the nose and sinuses but felt at another site. It may become generalized pain and tension in head and neck. It is one or all of these.

The Sinutab formula is designed for symptomatic relief of sinus headache.

It provides two analgesics to relieve pain and discomfort...an effective oral decongestant to reduce mucosal congestion...and an antihistamine to help control allergic manifestations.

Side Effects: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs.

Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

WARNER-CHILCOTT
Morris Plains, N.J.



SINUTAB®

for sinus headache

Each tablet contains
150 mg. acetaminophen,
150 mg. phenacetin,
25 mg. phenylpropanolamine HCl,
and 22 mg. phenyltoloxamine
citrate.

W-37-71-20



**Sinus
sphenoidalis**

**Os
occipitale**

Public Aid

(Continued from page 162)

Then, this is not a program with a fixed fee schedule?

No, this is a complete departure from the old idea of a fixed fee schedule. The new program follows rather closely the principles for payment of physicians as outlined under Title XVIII (Medicare) of the Social Security Act. We see this program as a vast improvement over previous approaches to physician reimbursement. I think it is clear that physicians have not been paid at a realistic rate in the past. The fee schedule used prior to Jan. 1, 1967, dated back to 1958, and recognition of its obsolescence is long past due.

What is the estimated cost of the new program?

As we see it, the adoption of this new plan will lead us from current expenditures of about \$7.5 million a year for physicians' services to expenditures of about \$15.5 million a year—or a little over double the present outlay. These expenditures will provide necessary physician services for about 400,000 citizens of Illinois.

Will the new program mean more physician participation in the Public Aid program?

I'm certainly optimistic that it will. I've already had some indication of interest. We hope, particularly, that more physicians will be encouraged to practice in those areas where there is a high concentration of public aid recipients and very few physicians. We have had difficulty attracting doctors to these areas because of the inadequate payment schedule.

How will you determine whether the fee a physician bills your department is his usual and customary fee?

In part, from data furnished us by ISMS as a result of its 1966 survey of the range of usual, customary and reasonable charges of its members. While we don't have a profile of the fees charged by every physician, we have a pretty accurate record of the usual

and customary fees charged in specific geographical areas.

What happens if your department thinks a doctor's fee is unreasonable?

I favor paying the doctor what the department feels is a reasonable and proper amount—then upon request, adjudicating the difference between what he charged and what the department paid. The alternative would be to pay nothing, but I don't believe this is desirable. Remember, we process some 80,000 doctor bills a month. We'd prefer to move all of them through the payment procedure and then discuss with the doctor those to which we take exception.

And if the doctor and your department can't agree, what then?

Provision has been made for a review of the matter by a committee selected by the department and ISMS.

What committee is this likely to be?

I should think it would be the county medical advisory committee to Public Aid. I understand that in some small counties, this committee is also the county society's Committee on Prepayment Plans and Organizations. I think we need to have a similar committee, or the same structure which we have had in the past, to come to grips with problems that we have had before and will have again.

Where should participating physicians send their bills?

Bills should be sent directly to the Department of Public Aid, 618 E. Washington St., Springfield 62706. Previously, bills were sent to the county public aid departments.

Why has this procedure been changed?

We have the facilities at Springfield to mechanically check the patient's eligibility and the propriety of the physician's charges. Then, too, mechanical processing should help speed payment while eliminating considerable clerical work in the county departments.

Are there other advantages to this central processing?

(Continued on page 239)

when it counts...

Chloromycetin[®]

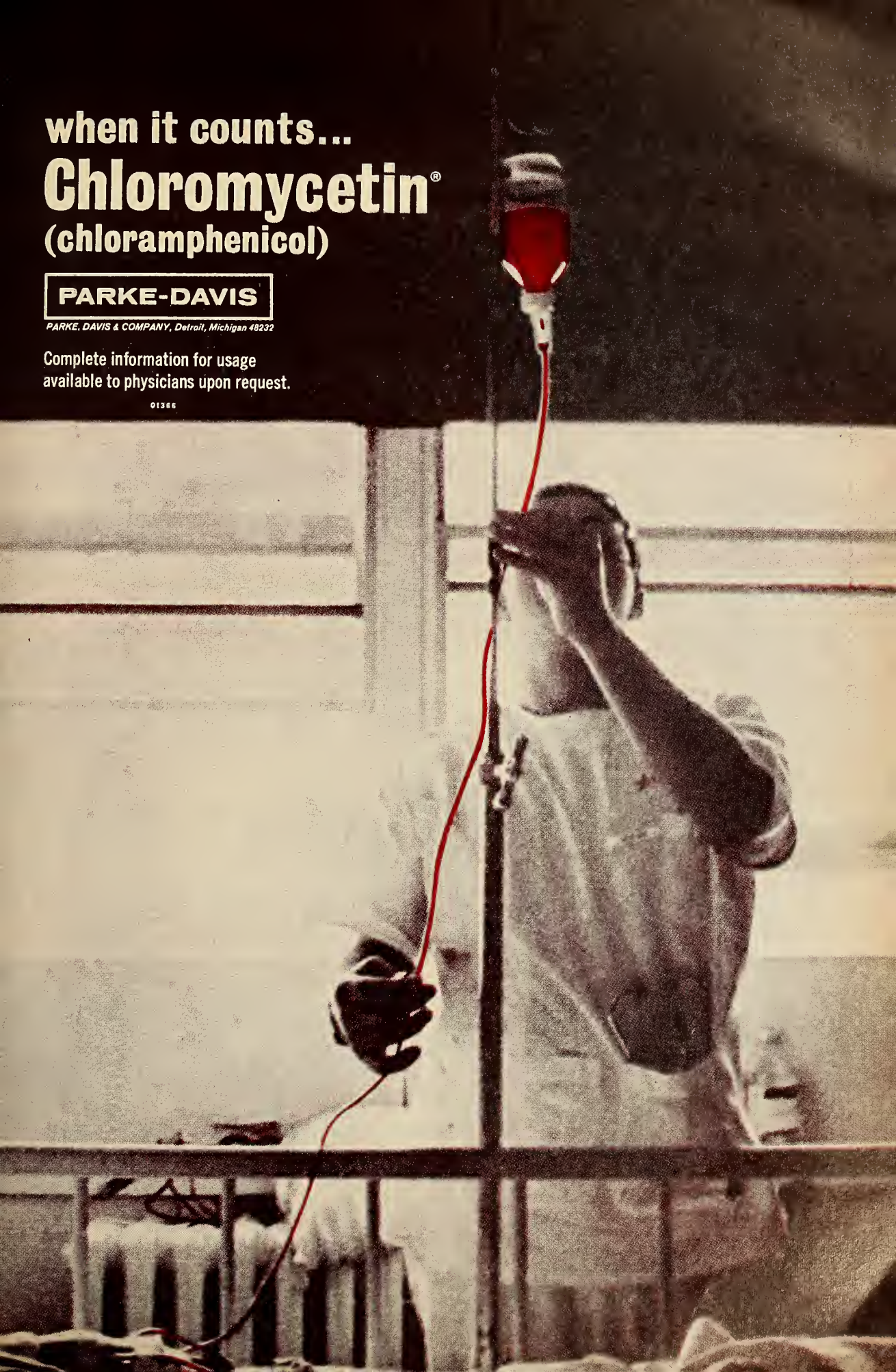
(chloramphenicol)

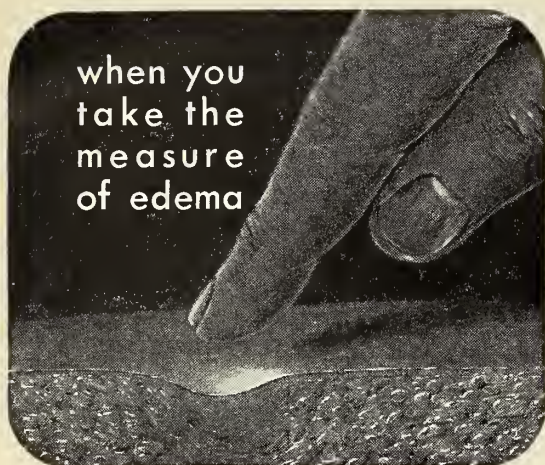
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Complete information for usage
available to physicians upon request.

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when you
take the
measure
of edema

... introduce your patient to

aquataG[®]
(BENZTHIAZIDE)

AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic tetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.



**S.J. TUTAG
& COMPANY**

Detroit, Michigan 48234

The Doctor's Library

SYMPOSIUM ON THE LENS. Edited by John E. Harris. The C. V. Mosby Company, St. Louis, 1965. 381 pages. \$18.50.

This volume is a collection of papers given at a symposium on the lens held in December, 1964, at the University of Minnesota. The 32 participants represent the outstanding authorities in the world on lens morphology, chemistry and metabolism. As might be expected the majority of the contributors were American but the presence of Nordmann from France, Rabaey from Belgium, Hockwin from Germany and Pirie from England insured that this would be an international symposium. The basic nature of the papers is shown by the fact that only 11 of the participants had M.D. degrees while 24 had doctorates in philosophy or its equivalent. (Three obviously had both.) The subjects covered ranged from experimental embryology to cell turnover to energy metabolism to cation transport. Although this was theoretically a symposium on the normal lens, several papers touched on the pathologic lens particularly in relationship to diabetes and aging.

In summary this is not a book that will appeal to the average clinical ophthalmologist, but is an absolute must for the research worker on the lens.

David Shoch, M.D.

Cancer

(Continued from page 197)

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6. Knock, F. E.: Sulfhydryl Inhibitors for Clinical Cancer Chemotherapy, *J. Am. Geriat. Soc.* 15:41-50, 1967.
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9. Együd, L. G. and Szent-Gyorgyi, A.: Cell Division, SH, Ketoaldehydes, and Cancer, *Proc. Natl. Acad. Sci. USA*, 55:388-393, 1966.

Public Aid

(Continued from page 226)

We think so. For one thing, it will help us accumulate considerable information on the physical conditions of patients, which, in turn, can guide us in the planning of a long-term medical program. Then, too, it will give us access to information about physicians which will be of value to both the department and the State Medical Society in evaluating the effectiveness of the program.

What form is required for billing purposes?

We are revising the old form M-132 to make it convenient for both physicians and the department. We will list on the front those six or seven procedures which comprise 80 percent of our volume—office visits, home visits, hospital visits and the like. On the back, we will list code numbers of as many of the more common procedures as space permits.

What do you mean by “code number?”

To facilitate the identification and evaluation of billings by machine, we will require that each procedure billed be identified by the code number assigned to it in the American Medical Association's *Current Procedural Terminology*.

What else must a doctor include on his bill?

We require that he list his AMA medical education number—which I understand has been supplied to him by ISMS—as well as the name of the county in which he has his business office and the patient's Public Aid identification number.

May hospital-based specialists — roentgenologists, pathologists, anesthesiologists, psychiatrists — bill your department directly for their usual and customary fees?

Yes. They can either bill the department or they can let their hospital bill us and then collect from the hospital. We will accommodate both types of arrangements.

Will a physician who assists at surgery be paid his usual fee?

Any procedure listed in the AMA's *Current Procedural Terminology* is reimburs-

able if it is identified as a separate item for which separate charges are made. For example, such distinction is made between routine or prolonged visits in home, office, or hospital and the department will recognize those differences.

Then you will recognize the difference between a routine and complicated office visit honoring physician bills?

Yes, if the physician explains what service he provided by using the appropriate code in the AMA's *Current Procedural Terminology*.

Will doctors be paid for administering preventive medicines?

The area of preventive medicine is one to which my department is committed, but on a “proceed slowly” basis. For the next biennium, for example, we will pay for physical examinations and the administering of vaccines for school children in those counties in which there is no coverage of these programs as a public service. There are many things that one can explore in this area of preventive medicine and we will be exploring them increasingly—but on that “proceed slowly” basis.

Will doctors be paid their usual and customary fees for hospital visits?

Yes, Again I say, the department will recognize usual, customary and reasonable fees for any and all procedures listed in *Current Procedural Terminology*.

Does the new program impose quantity limitations?

No, at least not in the beginning. However, we will post-audit bills to determine if quantity standards are necessary in an ongoing program. Certainly, we are hopeful that it won't be necessary to return to any utilization controls and we don't think it will be. But we do want to take a look at this again after six months to see what our experience has been.

What effect will this program have on the Drug Manual?

We don't foresee any effect. It may be necessary, primarily because of procedural problems, to provide for some different ap-

(Continued on page 242)



fluocinolone acetonide — an original steroid from

SYNTEX



LABORATORIES INC., PALO ALTO, CALIF.

controls infected inflammatory dermatoses that start from scratch



The "itch-scratch" cycle usually associated with inflammation often results in infected dermatoses because broken skin surfaces are particularly vulnerable to pathogenic bacteria.¹ To treat infected inflammatory dermatoses, Neo-Synalar Cream combines the most active topical corticosteroid with a highly reliable antibiotic generally reserved for topical application.

In Neo-Synalar, fluocinolone acetonide controls the inflammation and provides rapid relief from associated pruritus. At the same time, its antibacterial component—neomycin—combats superficial infection caused by many gram-positive and gram-negative bacilli² that often colonize and thrive on abraded skin.¹

A specially formulated vanishing cream base that is greaseless and odor free makes Neo-Synalar cosmetically appealing, and encourages greater patient cooperation.

controls the infection

stops the scratch

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of its components. **Precautions:** Neomycin rarely produces allergic reactions. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. **Side Effects:** Side effects are not ordinarily encountered with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Neo-Synalar under certain conditions. **Availability:** Neo-Synalar Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

References: 1. Pillsbury, D. M., Shelley, W. B., and Kligman, A. M.: A manual of cutaneous medicine, Philadelphia, Saunders, 1961, p. 79. 2. Barber, M., and Garrod, L. P.: Antibiotic and chemotherapy, Baltimore, Williams and Wilkins, 1963, p. 111.

Neo-Synalar®
(fluocinolone acetonide-neomycin sulfate cream)
Cream

Public Aid

(Continued from page 239)

proach to billings by physicians for dispensed drugs.

Will any program of care require prior approval from your department?

Usually, "prior approval" refers to hospitalization, which we no longer require. The only prior approval we will require—other than for prosthetics, major appliances and the like—will be drugs not listed in the Drug Manual.

Why must doctors accept assignments when treating Public Aid patients?

Because HEW will not allow direct billing of persons receiving assistance under Title XIX if they have benefits due under Title XVIII. You see, under Title XIX, my department cannot pay out public assistance funds until all other possible sources for meeting a medical need have been explored. Consequently, we can't pay out anything for medical expenses under Title XIX until the Title XVIII program have been utilized.

Do you see any advantages to direct billing?

There are both advantages and disadvantages to it. For example, direct billing may be more convenient and more expedient, but where Title XVIII might recognize \$8 as a reasonable charge for a particular procedure, the department may recognize only \$6 as reasonable.

Is your department behind in physician payments for services to public aid patients?

Only for services to patients under Part B of Medicare. We have had a backlog of several thousand duplicates of billing forms that have been sent to carriers under Part B, but we have had no word from the carriers as to whether all or none of the charges have been paid. And we can't process our copies until we get that word.

Can a physician order a chest x-ray for a patient?

Not if it's a preventive medicine procedure. However, if the x-ray is part of a diagnostic work-up, yes—we'll pay.

What general observations have you about the program?

Well, I would hope that the physicians will be patient with us in the beginning as we test check our machine programs. If a doctor has \$200 due him, we don't want to pay him \$2, \$20 or \$2,000 because of error—as sometimes happens. We will have to do some testing of our machine programs and this will take time.

Mr. Swank, what will be the single most important factor in the success of this new program?

Frankly, the program's success will be determined by the attitude of physicians. If they bill the department their usual and customary fees, I believe the program will work. However, if they begin shopping around to determine what is the maximum we will pay for any or all procedures, and increase their charges to those points, then the program will fail.

New Smallpox Certificates

"Smallpox vaccinations performed after Jan. 1 must be recorded on the new certificates to be valid for international travel," according to Dr. Franklin D. Yoder, director of the Illinois Department of Public Health.

All physicians have been notified to obtain a supply of these new certificates before the deadline. They are available from the Division of Foreign Quarantine, U. S. Public Health Service, Silver Spring, Md. 20910.

The prospective traveler should also check a smallpox certificate received after Jan. 1 to make sure he has been issued one revised September 1966.

This date appears on the lower left corner of the certificate cover. He should also examine the information and requirements mentioned in the certificate to make sure they are complete, including the record of the type of vaccine used, manufacturer's name and the lot number of the vaccine.

"This information is an important part of the new certificates," Dr. Yoder said. "Taking a few minutes time to check a certificate may well save the traveler much future trouble and inconvenience."

The new amended certificate is the result of the World Health Organization's policy-setting standards.

**NEW
PHARMACEUTICAL
SPECIALTIES**

by Paul deHaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Consisting of two or more active ingredients

New Dosage Forms—Of a previously introduced product.

NEW SINGLE CHEMICALS

SERC Vasodilator-microcirculatory R
Manufacturer: Unimed, Inc.

Nonproprietary Name: Betahistine HCl

Indications: Vertigo associated with Meniere's syndrome.

Contraindications: Active peptic ulcer; concurrently with antihistamines. Use caution in patients with pheochromocytoma and bronchial asthma.

Dosage: One or two tablets 2 to 4 times a day. Not more than 8 tablets should be taken in any one day.

Supplied: Tablets, scored—4 mg.; bottles of 100.

DUPLICATE SINGLE PRODUCTS

5% SODIUM BICARBONATE

IN WATER Hospital solution

Manufacturer: Baxter Laboratories

Nonproprietary Name: Sodium bicarbonate

Indications: Control of acid/base balance.

Dosage: I. V.

Supplied: Bottles, 500 cc.

SYTOBEX-H Hematinic R

Manufacturer: Parke, Davis & Co.

Nonproprietary Name: Hydroxocobalamin

Indications: All conditions manifesting a vitamin B₁₂ deficiency.

Contraindications: Allergic type of reactions have been reported on rare occasions.

Dosage: I. M.—100 ug or less depending on condition.

Supplied: Steri-Vials, 10 cc. containing 1000 ug.

TAASA Analgesic, non-narcotic o-t-c

Manufacturer: Haag, Inc.

Nonproprietary Name: Acetylsalicylic acid

Indications: For temporary relief of arthritis and rheumatic pain.

Contraindications: If no relief within 10 days, or redness is present consult physician immediately

Dosage: One tablet q4h, prn.

Supplied: Tablets—450 mg.; bottles of 100

COMBINATION PRODUCTS

HAZEL-BALM H-C Antipruritic—local R

Manufacturer: Arnar-Stone Laboratories

(Continued on page 251)



**He leaves to make
an urgent call
But doesn't use
the phone at all**

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects
intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent).....(1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid
ounce.

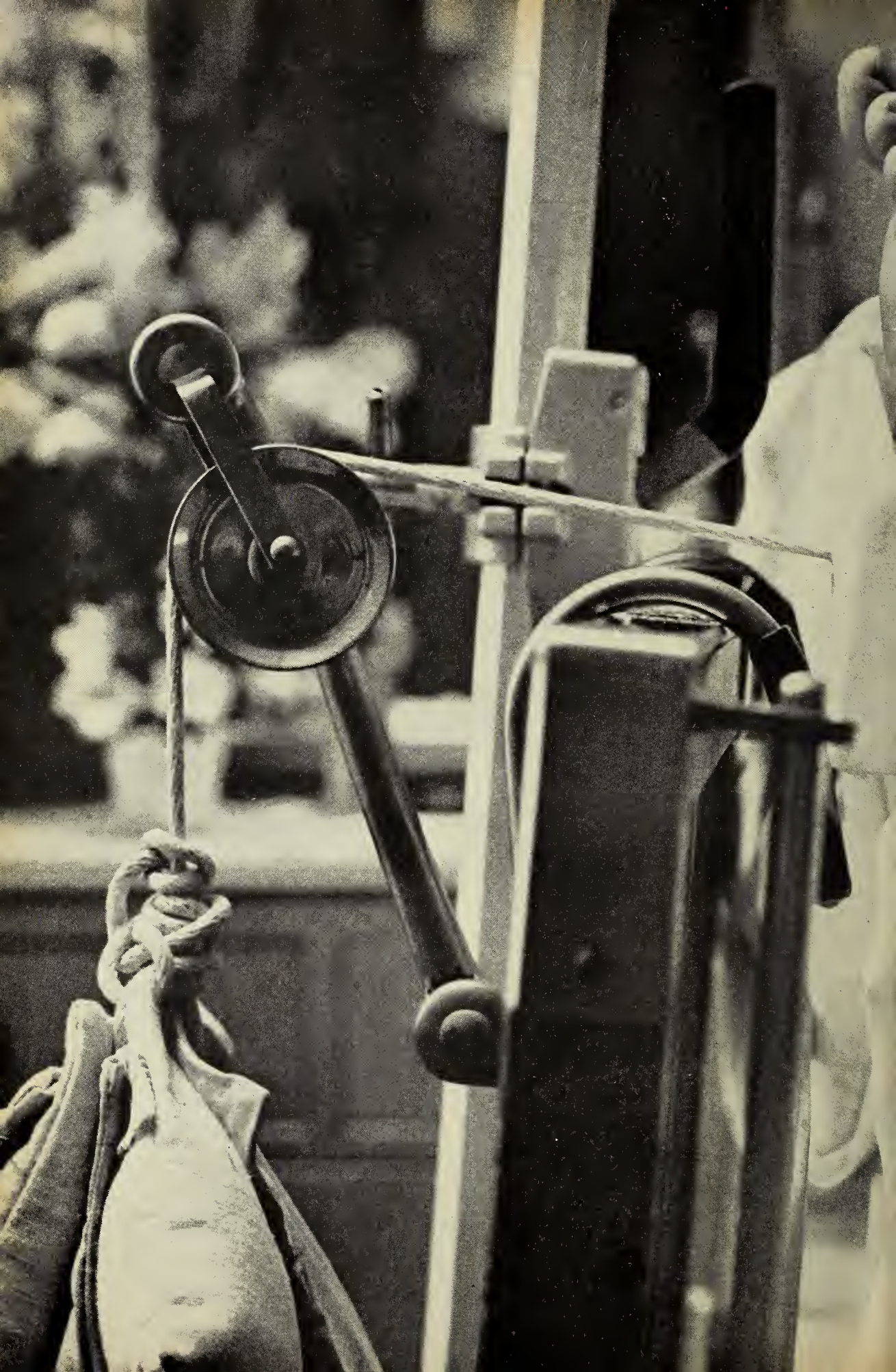
warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Adult Dose: One or two tablespoonfuls three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.



TABLETS

Equagesic[®]

(meprobamate and
ethoheptazine citrate with
aspirin)



Precautions: Keep out of reach of children. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. Give cautiously to patients with suicidal tendencies. Treat attempted suicide with immediate gastric lavage and appropriate supportive therapy.

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness and CNS depression. Overdosage may result in salicylate intoxication. Meprobamate rarely causes allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioedema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.
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Weighing on his mind, too

When pain evokes anxiety and tension, thereby heightening patient discomfort, a simple analgesic may only touch on part of the problem.

This single-prescription, non-narcotic product, however, usually provides effective analgesia *and* helps put the patient's mind at ease.

CERTIFIED AS EXTENDED CARE FACILITIES IN ILLINOIS

as of Jan. 30, 1967

In a continuous effort to keep Illinois physicians up to date on programs and facilities available for the aging, the ISMS Committee on Aging provides the latest directory of certified extended care facilities in Illinois. While this directory lists 109 ECF's available as of Jan. 30, 1967, the Illinois Department of Public Health plans to eventually certify about 350 facilities.

Name	City	Beds	Name	City	Beds
Arthur Home	Arthur	42	Wrightwood Nursing Home	Chicago	90
Aurora Borealis Nursing Center	Aurora	112	Park Hill Nursing Home	Chillicothe	66
Memorial Home	Belleville	111	Oak Glen Nursing Home	Coal Valley	286
Franklin Hospital Skilled Nursing Care	Benton	81	Americana Nursing Center of Decatur	Decatur	65
Fairfax Geriatric & Convalescent Center	Berwyn	106	Lakeshore Manor	Decatur	76
R. N. Convalescent Nursing Home	Berwyn		Pine Acres Ret. Center	DeKalb	60
Heritage Manor	Bloomington	86	Gulf Road Pavilion Nursing Home Inc.	DesPlaines	142
Casey Nursing Home	Casey	92	Orchard Glen, Inc.	Dixon	54
Centralia Fireside House	Centralia	92	Fair Acres Nursing Home	DuQuoin	74
St. Ann's Home	Chester	45	Simpson House Ltd.	Elgin	35
Alshore House	Chicago		Elmhurst Nursing Home, Inc.	Elgin	
Augustana Home for the Aged	Chicago	28	Three Oaks Nursing Center	Evanston	124
Austin Congress Nursing Home	Chicago	136	Evergreen Gardens	Evergreen Park	40
Bethany Methodist Hospital Geriatric Division	Chicago	87	Peace Memorial Home	Evergreen Park	160
Bryn Mawr House	Chicago	183	Americana Nursing Center	Galesburg	67
Carmen Manor	Chicago		Golf Mill Nursing Home	Glenview	
Dearborn House	Chicago	128	Blu-Fountain Manor	Godfrey	75
Drexel Home	Chicago	245	Hammond Henry Dist.	Geneseo	48
Elston Nursing Home	Chicago		Villa St. Cyril	Highland Park	13
Fargo Beach Home	Chicago	143	Pavilion of Highland Park	Highwood	59
Fox River Rehabilitation Center	Chicago	74	Hopedale Nursing Home	Hopedale	86
Garden View Home	Chicago	130	Modern Care Conv.	Jacksonville	40
Jewish Home for the Aged	Chicago	232	Americana Nursing Center of Joliet	Joliet	9
Johnson Rehab. Nursing Home	Chicago	76	Our Lady of Angels Retirement Home	Joliet	
Kostner Manor	Chicago	119	Salem Home for the Aged	Joliet	26
Melbourne Convalescent Home	Chicago	170	Americana Nursing Center	Kankakee	92
Montgomery Convalescent Home	Chicago	80	The Methodist Home for the Aged	Lawrenceville	40
Northwest Home for the Aged	Chicago	50	Lake County Nursing Home	Libertyville	153
Park House	Chicago		Abraham Lincoln Meml. Extended Care	Lincoln	53
Park View Home	Chicago	21	Christian Nursing Home	Lincoln	48
South Shore Kosher Rest Home	Chicago	90	Mary Henry Nursing Home	Lincoln	52
South Shore Pavilion	Chicago	113	Americana Nursing Center	Macomb	56
Westwood Manor	Chicago	115	Douglas Nursing Center	Mattoon	49
			Americana Nursing Center of Moline	Moline	67
			Restmor	Morton	78

<i>Name</i>	<i>City</i>	<i>Beds</i>	<i>Name</i>	<i>City</i>	<i>Beds</i>
Pinecrest Manor	Mt. Morris	122	Esma A. Wright		
Hickory Grove Manor	Mt. Vernon	99	Conv. Center	Robbins	50
Woodland Inc, Nursing Center	Mt. Zion	70	Americana Nurs. Ctr. of Rochelle	Rochelle	49
North Riverwood Manor	Mundelein	65	Americana Nursing Ctr. of Rockford	Rockford	114
Jackson County Nursing	Murphysboro	158	Riverside Manor	Rockford	108
Americana Nursing Center	Naperville	95	Hardin Co. Gen. Hospital	Rosiclare	4
Americana Nursing Center	Normal	95	Old Orchard Manor	Skokie	61
Eden View & Geriatric	Northbrook	57	Suburban Conv.	S. Chicago Heights	49
Oak Forest Hospital	Oak Forest	1393	Americana Nursing Center of Springfield	Springfield	114
Oak Lawn Conv. Home	Oak Lawn		Homestead Conv. Home & Nurs. Resid.	Springfield	60
Monticello Conv. Center	Oak Lawn	99	Rutledge Manor Care Home	Springfield	46
Highland San & Conv. Home	Ottawa	63	Colonial Acres Rest Home	Sterling	70
Pleasant View Luther Home	Ottawa	146	Heritage Manor	Streator	57
Pekin Mem. Hosp.	Pekin	39	East View Nursing Home	Sullivan	52
Americana Nursing Center of Peoria	Peoria	65	Iroquois Resident Home	Watseka	58
Fireside House	Peoria	108	Washington Nursing Center	Washington	51
High View Nursing	Peoria	66	Monroe Co. Nursing Home	Waterloo	182
Heritage Manor Nursing	Peru	55	The Terrace Nursing Home	Waukegan	112
Menard Conv. Center	Petersburg	54	Waukegan Pavilion Nurs.	Waukegan	96
Methodist Sunset Home	Quincy	64	Abbey-Winfield Geriatric	Winfield	48
St. Joseph Hall	Quincy	72	DuPage Conv. Home	Wheaton	288

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The **HOSPITAL OF CHOICE**

North Shore Hospital, a 65-year-old psychiatric facility located on Lake Michigan in Winnetka, Illinois, is an intensive care hospital.

An open staff institution, it provides, through its house and attending staff, a total range of psychotherapies and those related activities which round out a comprehensive treatment program.

A new Half Way Hall, situated in the hospital, has been opened to provide relative freedom of movement in an environment designed to stimulate recovery and provide a necessary phase of interim residence.

A completely open section is a feature of North Shore Hospital's residential plan.

An adolescent program offers boys and girls of high school age a closely-structured program of daily care, with daily classroom attendance and individual tutoring emphasized.

The adjunctive therapies are manned by certified personnel. Occupational and recreational activities not only help structure the patient's day, but offer creative programs in which patients participate according to their emotional health and native capacity.

A therapeutic education program has been introduced for all patients. Medicare patients are offered special attention and remotivation activities.

Psychiatric testing and evaluation is offered, as is individual and group therapy, chemotherapy and the traditional modalities employed in the treatment of emotional illness.

In reputation, performance and location, North Shore Hospital is the psychiatric hospital of choice.



For information, contact:
MILTON A. DUSHKIN, M.D.
Medical Administrator
Telephone: 312-446-8440
225 Sheridan Road, Winnetka, Illinois
(Write for Brochure)

Surgical Grand Rounds

(Continued from page 166)

nerve. Ear pain is usually due to vagal involvement and vagal pain is involved in the glossopharyngeal form of neuralgia. The upper cervical roots also contribute to the sensory supply of the head, neck and face. I do not think that this patient should be considered as having glossopharyngeal neuralgia in the usual sense.

Fiedler's Myocarditis

(Continued from page 179)

Block of the Refractory Period of the Heart of the Dog, Heart 8:229-295, 1921.

27. Wennemark, J. R., Benvenuto, R., and Lewis, F. J.: Destruction of the Specialized Conduction Tissue in the Live Canine Heart with Iodine, J. Thor. Cardio. Surg. 39:137-143, 1960.
28. Wennemark, J. R., Blake, D. F., Kezdi, P. and Lev, M.: Extensive Intraventricular Conduction Defect. Experimental Production with Destruction of the Total Purkinje-net system of the Canine Right Ventricle, Circulation Res. 11:904-909, 1963.

Schistosomiasis

(Continued from page 190)

During the care of this patient the incidence in the state of two more cases of schistosomiasis came to the attention of the author. One was a case of schistosoma mansoni infestation in a national of Mali, at a nearby military base. The other was the case of Schistosoma haematobium being found incidentally in the urinary tract of a national from Ghana. The diagnosis was made at the University of Illinois Research and Educational Hospital, Chicago, during study of a chronic renal condition.

The intermediate host of the schistosomiasis parasites are freshwater snails. The genus *Bulinus* serves for schistosoma haematobium; *Planorbis* for schistosoma mansoni; and *Oncomelania* for schistosoma japonicum. None of these are found in the United States. There remains the possibility, however, that some other genus common to the United States might accidentally become a suitable host and then a serious threat to public health would exist. A suitable laboratory snail host for schistosoma mansoni has been found in Louisiana, Texas and Florida.

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OBITUARIES

***Dr. Edward A. Fahnestock**, of St. Louis died Dec. 6 at the age of 60. A graduate of Northwestern University Medical School who started practice in Carmi in 1932, he was a member of the Illinois State Medical Society Ethical Relations Committee.

***Dr. G. Kenneth Lewis**, Chicago, died Jan. 17 at the age of 65. He was chief plastic surgeon at Christ Community Hospital in Oak Lawn, and was on the staff of South Shore and Illinois Central Hospitals. He had been a plastic surgeon for more than 35 years.

Dr. John P. Mayka, Chicago, died on Jan. 20 at the age of 60. He was retired from the Callahan clinic where he had practiced for 20 years.

***Dr. C. C. Meeks**, Fairbury, died Jan. 8 at the age of 87. He was a graduate of University of Illinois College of Medicine and was a member of the Livingston County Medical Society.

Capt. William Ellis Pinner (MC) USN, ret., San Diego, died Dec. 18 at the age of 68. A Navy medical officer for 30 years and a noted radiologist, he was a member of the American College of Radiology.

***Dr. Louis L. Vitt**, Wee Ma-Tuk, died at the age of 75 on Dec. 11. Dr. Vitt who had

served as Fulton County Public Health Service director since 1947, received his B.S. and M.D. degrees from Loyola University and his master of public health degree from Vanderbilt University. He was founder of the Well-Child Clinic in Canton.

***Dr. John L. Snavelly**, Sterling, died Jan. 15 at the age of 87. He received his pre-medical education at Northern Illinois Normal School, attended the University of Iowa Medical College, and graduated from Hahnemann Medical College in 1904. He was active in the founding of the Sterling Public Hospital and a member of its board for many years.

Dr. G. Norman Adamson, Chicago, died at the age of 69 on Jan. 28. He had been a physician and surgeon in Chicago for more than 33 years. A graduate of Talledega College in Alabama, and of Meharry Medical College in Nashville, Tenn. Dr. Adamson served as battalion surgeon of the 761st Tank Battalion during World War II, and was awarded the Bronze Star and Purple Heart. He was past president of the Cook County Physicians Association.

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Pharmaceutical Specialties

(Continued from page 243)

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Hamamelis Water 79.16% w/w
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Buffered with sodium citrate and
citric acid.

Indications: Contact dermatitis, pruritus ani et
vulvae, atopic dermatitis, neurodermatitis, and
seborrheic dermatitis.

Contraindications: Tuberculosis of the skin,
herpex, simplex, vaccinia, varicella and other
infections for which an effective antibacterial
agent is not available.

Dosage: Spray area as required.

Supplied: Aerosol containers of 3 ounces.

OBLATE PLUS Vitamin/Mineral

Comb.—Prenatal o-t-c

Manufacturer: Haag, Inc.

Composition: Vitamin A, D, B complex, C and
minerals (seven).

Indications: As a dietary supplement.

Dosage: One tablet daily or as directed by phy-
sician.

Supplied: Tablets, capsule-shaped.

SEDALIXIR Sedative and Hypnotic

Combination R

Manufacturer: Walker Laboratories

Composition: Each 5 cc. contains:
Pentobarbital sodium 8.1 mg.
Phenobarbital 16.2 mg.

Indications: Tension and anxiety states, insom-
nia, and convulsive disorders.

Contraindications: Known sensitivity to barbitu-
rates, use with caution in liver and renal dys-
function.

Dosage: Adults and children over 6:

Daytime sedation—1 tsp. 3 or 4 times
daily.

Nighttime sedation—2 to 3 tsp. upon
retiring.

Children under 6:

¼ tsp./Kg. body weight per 24 hour
period.

Supplied: Bottles—6 oz.

SPEC-T Troches Cold Preparations

General o-t-c

Manufacturer: E. R. Squibb & Sons

Composition: Cetylpyridinium chloride
Benzocaine

Indications: Temporary relief of minor sore
throat.

Contraindications: Do not use for more than 2
days or administer to children under 3 with-
out physician's instructions.

Dosage: Dissolve one troche slowly every 3 or
4 hours.

Supplied: Boxes of 10 troches in 2 foil packs.

C-RON TC Hematinic Vitamin Combination

o-t-c

Manufacturer: Rowell Laboratories, Inc.

Composition: Ferrous fumarate 100 mg.
Ascorbic acid 300 mg.

Indications: Iron deficiency anemia, and prophy-
laxis against iron deficiency anemia of preg-
nancy.

Dosage: Two to six tablets daily.

Supplied: In bottles of 100, 1000 and 5000

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Educational Programs

By RUTH G. CHRISTENSEN

The successful doctor today requires a medical office assistant capable of handling the many details brought about by our modern civilization. The effect that the medical assistant has on the doctor's practice and efficiency is much greater than he may realize. Medical assistants do realize this and therefore are attempting to acquire more knowledge in an effort to do a better job for their physician-employers. Since formal medical assistant training was unavailable until a few short years ago, assistants are gaining this education through their membership in IMAA, especially in county-sponsored study groups.

The turn of the year has seen great activity begin in the educational programs sponsored by the local Medical Assistants' Association chapters. While the courses are designed to prepare those who wish to become Certified Medical Assistants (CMA's) for the examination they are required to pass, all members are encouraged to attend.

Beginning in January, Du Page County sponsored a series of bi-weekly lectures presented by the Du Page County Bar Association. The subject is Medical Law. The series is divided into three sections:

- I. The Legal Aspects of the Doctor-Patient Relationship
- II. Malpractice (Professional Liability)
- III. The Physician's Public Duties

The first was taught by Thomas Kel-

leghan, the second by Robert Cox, and the third by William Hopf, Du Page County States Attorney. This series is in addition to the regular monthly meetings.

Kane County has begun a new series of weekly classes which will run for the next 18 months. They are being taught by Dr. Donald Dick of St. Charles. This series of classes is being attended not only by Kane County members, but members from Du Page and Lake Counties as well. The classes are being held at Delnor Hospital and will cover the entire study outline supplied by the Certifying Board of the American Association of Medical Assistants.

As each system of the body is studied, the anatomy, physiology, medical terminology, and x-ray, laboratory, and x-ray procedures will be covered for that system before moving on to another.

Adams County has just completed a four-year program covering various aspects of the field of medical assisting. This group used the book *The Medical Assistant* by Miriam Bredow as the center around which many of their programs were built.

Other chapters throughout the state of Illinois are conducting similar programs aimed at educating their members in order that all may be better prepared to perform their job. Members from many chapters have also been enrolled in special courses at local colleges or other adult education classes.

Meetings

(Continued from page 213)

Mar. 10—"Cell Differentiation in Tissue Culture" by Yale J. Topper, Chief, section on intermediary metabolism, National Institute of Arthritis and Metabolic Diseases.

Mar. 5-8—Chicago Medical Society's Annual Clinical Conference will be held at the Palmer House, Chicago. Highlights of the opening day include a "Medico-Surgical Symposium on Intensive Cardiac Care;" Herbert L. Ley, Jr., Director of the Bureau of Medicine for the Food and Drug Administration, speaking on "Problems of Drug Regulations and Licensing"; Kenneth G. Kohlstaedt, vice president in charge of medical research for Eli Lilly, discussing "Clinical Evaluation of a New Drug in 1967," and programs on diabetes and gout.

On Tuesday there will be a symposium on cancer of the reproductive organs and discussion of the regulation of the ovulation cycle in women, German measles vaccine, prevention of iso immunization, management of premature rupture of membranes, and the pregnant adolescent.

Highlights of Wednesday's program include talks on psychedelic drugs, computers in surgical practice, recurrent peptic ulceration and panels on surgery and radiology.

Instruction courses during the week are in diseases of the breast, cardiac diseases, and metabolic and endocrine diseases.

Mar. 8—Frontiers of Medicine, a seminar on the "Nature and Management of Inflammatory Bowel Disease," coordinated by Joseph B. Kirsner, M.D., and John V. Prohaska, M.D., will be conducted at 2 p.m. at the University of Chicago Hospitals and Clinics.

Mar. 11—Journalism Awards Dinner at the Ambassador Hotel, Chicago. Sponsored by the ISMS Committee on Public Relations, the dinner will be the setting for awarding citations of merit to radio, television and the press for achievement in communications contributing to a better public understanding of medicine and health in Illinois. Award winners will be entered in the American Medical Association journalism competition for 1966, which offers a cash prize of \$1,000 in each category.

(Continued on page 255)

COOK COUNTY Graduate School of Medicine CONTINUING EDUCATION COURSES

Starting Dates—1967

SPECIALTY REVIEW COURSE IN SURGERY, PART II, March 6
SPECIALTY REVIEW COURSE IN MEDICINE, PART II, March 6
SPECIALTY REVIEW COURSE IN ORTHOPEDICS, April 10
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
ESSENTIALS OF PLASTIC SURGERY, One Week, April 3
PROCTOSCOPY & VARICOSE VEINS, One Week, March 13
GALLBLADDER & SURGERY OF HERNIA, Three Days, March 6 & 9
ADVANCES IN ORTHOPEDICS & FRACTURES, One Week, March 13
THORACIC SURGERY, One Week, April 3
OBSTETRICAL ANALGESIA & ANESTHESIA, Three Days, March 29
OBSTETRICS, General & Surgical, One Week, April 10
GYNECOLOGY, Office & Operative, One Week, April 3
VAGINAL APPROACH TO PELVIC SURGERY, One Week, March 6
BASIC ELECTROCARDIOGRAPHY, One Week, March 13
GENERAL PRACTICE REVIEW, One Week, April 3
ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

Information concerning numerous other continuation courses available upon request.

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INTERNIST to join Multi-Specialty Group. Salary \$20,000 first year, \$25,000 second year with partnership option thereafter. Medical school affiliation available. Write to: Prairie Clinic, 26th & J Streets, Omaha, Nebraska.

ANESTHESIOLOGIST needed for 750-bed private hospital in Mid-West. Minimum starting income for young man \$25,000 with rapid advancement. Considerably higher income for more experienced man. Contact Dr. John R. Shields, St. John's Hospital, Springfield, Illinois.

EXCEPTIONAL OPPORTUNITY for General Practitioner to join 3-man group in rapidly expanding general and industrial practice. West Central Illinois. Salary unimportant. Early partnership. Send resume. Beardstown Clinic.

GENERAL SURGEON, Internist, Family Physician (Generalist) Interested in satisfying practice with time for home life. Long established mixed Generalist and Specialist group in Greater Kansas City area. Rapidly growing community, excellent hospital facilities. Salary one year, then partnership. Raytown Clinic, 9406 E. 63rd St., Raytown 33, Missouri.

GENERAL PRACTITIONER wanted to join well-established practitioner. New clinic building—90 miles east of St. Paul—city of 14,000. Early partnership with full hospital facilities. Ideal location. L. W. Picotte, M.D., Chippewa Falls, Wisconsin.

OPENING FOR UROLOGIST, SURGEON AND INTERNIST. 1680-bed general medical-surgical and psychiatric hospital with excellent facilities and progressive staff; an equal opportunity employer. Salary \$12,873.00 through \$23,013.00 according to training and experience. Write to Director, VAH, Danville, Illinois.

OPENING FOR PSYCHIATRIST, SURGEON AND GENERAL PRACTITIONER. (Psychiatric or geriatric experience desirable but not essential.) 1680-bed general medical-surgical and psychiatric hospital with excellent facilities and progressive staff, an equal opportunity employer. Salary \$12,873.00 through \$23,013.00 according to training and experience. Write to Director, VAH, Danville, Illinois.

PSYCHIATRIC RESIDENCIES—Positions available January and July 1967. Fully approved; balanced didactic and clinical program. Three programs from which to choose: Three-Year Program, \$8,352 to \$9,500; Five-Year Career Program, \$9,500 to \$17,184; N.I.M.H. General Practitioner stipends, \$12,000. Located in Michigan's Water Wonderland. Contact Dr. Paul Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan. An equal opportunity employer.

FULL TIME SALARIED POSITION in General Practice, new modern air-conditioned building, modern laboratory and X-ray facilities available for your convenience. Please write Callahan Clinic, 4849 Fullerton Avenue, Chicago, Illinois 60639.

GENERAL PRACTITIONER—If you like the advantages of small village living (1850 pop) but only an hour's drive from Chicago and with good professional growth potential. Call collect 312-258-3814. Fred R. Meyer, Pres., Peatane Chamber of Commerce.

FELLOWSHIP IN MARITAL THERAPY—This is an approach to psychotherapy in which the marriage itself is considered to be the patient. Training and supervised experience by one of the U.S.'s foremost authorities in this field. Annual stipend — \$18,000. Apply to: Dr. Mortimer Gross, Forest Hospital, 555 Wilson Lane, Des Plaines, Illinois 60016.

PSYCHIATRIC residencies July, 1967: Approved three-year progressive program in Metropolitan Detroit area. University associations. Teaching staff of board men, psychoanalysts, professors, outstanding visiting lecturers. Active research. Modern physical plant. Salary \$8,978, \$9,405, \$10,213. Five-year career program \$10,232 to \$18,507. Liberal Civil Service benefits. General practitioners completed internship four years ago may be eligible for NIMH stipends of \$12,000 per year. Write, Director of Education and Research, Northville State Hospital, Northville, Michigan 48167.

Sales and Rentals

MODERN—MEDICAL—Dental Bldg. Office available March 1, 1967. Nine rooms. 900 sq. ft. Pediatrician present occupant. Parking, air conditioning; near downtown. Write Dr. T. Wise, 307 West University, Champaign, Illinois.

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Meetings

(Continued from page 253)

Mar. 11-12—Illinois State Medical Society Board of Trustees meeting, Ambassador Hotel.

Mar. 15—"Medical Implications of the Current Abortion Law in Illinois," A symposium sponsored by the Illinois State Medical Society. Robert R. Hartman, M.D., chairman of the ISMS Committee on Maternal Welfare, will moderate discussion on the maternal, fetal, mental health and public health aspects of the abortion law and reasons for and against changing it. Admission to the symposium, to be conducted at the Sherman House in Chicago, will be strictly by reservation.

Mar. 20-23—44th annual meeting of the American Orthopsychiatric Association, Washington, D. C. Theme of the meeting, which is expected to draw 9,000 psychiatrists, psychologists, social workers and others, is "The Impact of Schools in Human Development—a Critical Appraisal of a Social Institution."

Mar. 29-31—A symposium on "Immunologic Approaches to Mechanisms of Cutaneous Disease" will be held at the New York University Medical Center. Registration information may be obtained from the Office of the Recorder, New York University Medical School, New York 10016.

* * *

A third set of 12 *Timely Tips* is being prepared by the AMA's Department of Health Education. The two sets published earlier are among the most popular of AMA publications. *Five leaflets* in the third set are available now. *Timely Tips* contain brief but pertinent information on health problems. For example, new topics include "How to Be a Good Patient," "VD's Dubious Distinction," "Measles Vaccine," "Aid for Acne" and "Stock Up For First Aid." These leaflets are ideal as envelope stuffers accompanying monthly statements and also can be used by industries as pay check inserts. They are available for 20 cents per 100 copies of a single *Timely Tip*; 15 cents per 100 in lots of 500 or more; and \$1.50 for 100 complete sets of 12 *Timely Tips*.

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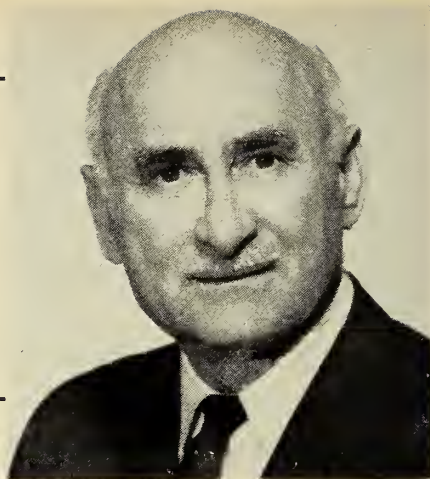
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*Schiller, I. W., and Lowell, F. C.: New England J. Med. 261:478, 1959.

The president's page



Caesar Portes, M.D.

Regional Medical Programs Heart, Cancer, Stroke

The medical profession and organized medicine are constantly on the alert to avoid, if possible, the socialization of medicine. Doctors throughout the country feel it is better for the health of the people of this country if medicine remains as a free enterprise. The relationship between the patient and doctor should be on a very personal basis and should not be influenced by government and bureaucracy.

For many years we have avoided the encroachment of the federal government in the field of medical care. We have staved off the many attempts by various administrations in Washington to institute some form of government sponsored "medicine." However, it seems that through the political power of the present administration in July of 1966, the Medicare program came into effect. At first, our concern was with Title 18. However, we now realize that Title 19 is the one with which we should be more concerned because that is the beginning of socialized medicine.

No sooner were we involved in this program concerning Medicare when a new law regarding the Regional Medical Centers for Heart, Cancer and Stroke was passed. We as doctors are not aware of the potentials of this program as yet. We should become aware that this is a problem with which we should be concerned greatly because to me it seems this is socialized medicine. However, we have the power and ability to withhold this encroachment upon medicine if only we would combine and work together and explain to the public

and to the government the objections that we have to this program. Certainly no such program can be successful without the cooperation of the doctors.

Recently I had the privilege of being present in Washington, D. C. at the conference of members of the Regional Medical Program Advisory groups from all of the states in the union. Several general meetings were held with speakers from H.E.W. and a number of small study groups were held to discuss the problems pertaining to these regional programs in each individual state.

I have listened to a great amount of brain washing and discussion on the importance of having these medical centers throughout the United States because of the "gap" that is existing in the health care of the people of this country. I somehow was resentful of this term "gap" and also felt that there was no tremendous deficiency in the care of the people in this country. I feel that we have made progress and are continuing to make progress in the treatment of heart, cancer and stroke. Cancer patients that were doomed to die years ago are now given at least five-year cures and many are totally cured by means of surgery, radiation and chemo-therapy. Victims of heart disease are having their lives lengthened with new advances in medical management and heart surgery. Certainly a great deal of progress has been made in vascular surgery and many of these individuals who have succumbed to strokes

(Continued on page 337)

'Bettercare' Is Theme of Annual Meeting May 21-24

"Bettercare" has been chosen as the theme of the 1967 convention of the Illinois State Medical Society which opens May 21 at the Sherman House in Chicago.

Section chairmen are now making final arrangements for programs to be announced in the April issue of the *Illinois Medical Journal*, which will also carry annual reports of all committees and a complete schedule of House of Delegates meetings.

The House will meet Sunday, Tuesday and Wednesday afternoons, with Reference Committee meetings Sunday evening.

The scientific program will open on Monday, May 22, with programs on Occupational Health, Mental Health Department Physicians and the Illinois Ob-Gyn Society in the morning, and sections on

Surgery and Neurology and Psychiatry in the afternoon.

The Public Affairs Dinner and the annual Camp Lecture will be combined this year on Monday evening.

Tuesday morning there will be sections on Ob-Gyn, Allergy, and Internal Medicine, and the sections on Radiology, Physical Medicine, and Public Health will meet on Tuesday afternoon.

Sections on Pediatrics, Dermatology, EENT, and Pathology will meet Wednesday morning, and the Section of Anesthesia in the afternoon.

Also on the final afternoon there will be a mental health symposium sponsored by the Chicago Medical School and a program on hemophilia.

Of special interest to members of the Illinois Medical Society—particularly those who will be officially representing their county organizations in the 1967 House of Delegates—is an informational section appearing in the April *Illinois Medical Journal* concerning the functions of the House and the responsibilities of delegates. In this article Dr. Edward W. Cannady, Speaker of the House, explains the vital role played by the House in the affairs of the society.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Physician Compensation For Utilization Review

Physicians may be paid for their services on utilization review committees for extended care facilities—if their county medical society approves the policy. The compensation is paid by the ECF, which is then reimbursed by Medicare. County medical societies which provide utilization services for all ECFs in the area may be reimbursed for their expenses—again by the ECFs. A society wanting to establish such a committee can write the ISMS Committee on Aging for suggested guidelines. The material includes a slide presentation which explains how ECFs affect physicians.

New Certification Regulations Listed

Physicians and providers of service will have flexibility in deciding how they will meet Medicare's certification and re-certification requirements. HEW will not require that a specific form or procedure be used by physicians, but re-certification statements should include: (1) An adequate written record of the reasons for continued hospitalization; (2) The estimated period of time the patient will need to remain hospitalized; and (3) Any plans, where appropriate, for post-hospital care. The ISMS Board of Trustees has taken the position that until all certification requirements are eliminated, the manner of meeting existing requirements should be an internal decision between the provider and the medical staff. The board has reaffirmed its opposition to special forms for certification and re-certification other than the usual hospital records containing adequate progress notes.

Proper Billing Speeds Payment

Here's the proper procedure for submitting statements for services to patients who are both Medicare and Public Aid recipients: Complete Social Security Form 1490 in duplicate. Include the patient's Medicare claim number, his public aid case number, and *your* AMA Medical Education Number. Send the original to the Medicare carrier, and the copy to the Illinois Department of Public Aid, 618 E. Washington St., Springfield. The department will process the \$50 deductible and the 20 percent co-insurance amounts after it has been notified of the carrier's payment.

Your M. E. Number

If you misplace your AMA Medical Education Number mailed to you by ISMS, call your county public aid department. Each county department has a list of the numbers for all physicians in that county.

How New Wage Law Affects You

Illinois physicians in private practice may have to raise salaries of their employees. The reason? The new minimum wage law which went into effect Feb. 1. While your employees are not specifically included under the Fair Labor Standards Amendments of 1966, they may be attracted by salaries from employers who must pay the new minimum rates. This includes public or private hospitals and institutions caring for the sick, the mentally ill, the defective, and the aged—who live on the premises. The new minimum hourly wage is \$1 for newly-covered employees and \$1.40 for employees previously covered. In five years, the minimum for all will be \$1.60.

Public Aid—Where it Goes

Some 410,814 Illinois residents—3.9 percent of the population—received public aid last November. In that month, the latest for which statistics are available, payments totaled \$24,868,479. Counties with the highest NUMBER of recipients include: Cook, 272,502 recipients (5 percent of the county population); Macon, 4,701 (3.8 percent); Madison, 7,021 (2.9 percent); Peoria, 5,713 (2.8); St. Clair, 27,956 (10.4 percent) and Winnebago, 4,594 (1.9 percent). Counties with the highest PERCENTAGE of recipients are: Alexander, 19 percent of the county population (2,770 recipients); Gallatin, 12.8 percent (911); Hardin, 13.7 percent (726); Pope, 12.9 percent (463); Pulaski, 27.5 percent (2,609); Saline, 10.1 percent (2,349); and St. Clair, 10.4 percent (27,956).

Medicare Payments In Illinois

Here's a breakdown on Medicare expenditures in Illinois: **Blue Cross**—Through Dec. 31, payments for hospital care totaled nearly \$51 million. A total of 109,230 bills were paid. **Blue Shield**—Through Dec. 31, payments under Part B totaled more than \$2.5 million. A total of 50,729 bills were paid—while 52,538 were disallowed, primarily because of failure to meet the \$50 deductible or because the claimant was not enrolled under part B. (Blue Shield is the fiscal intermediary in Cook, DuPage, Kane, Lake and Will counties.) **Continental Casualty Co.**—Through Jan. 31, payments under Part B totaled nearly \$2.5 Million. Continental—Part B intermediary for 97 counties—processed 131,000 bills, but did not indicate the number it paid. Nationally, nearly \$1 billion was paid through Dec. 31 for hospital care of more than 2.5 million Medicare recipients. More than \$100 million was paid for physicians' services to more than 3.5 million recipients.

Note These Important Deadlines

Mark your calendar—April 17 is the deadline for filing your declaration of estimated income tax for the calendar year 1967. And remember, you must include your social security tax in estimating your total tax payment. Self-employed persons are taxed at the rate of 6.4 percent on the first \$6,600 earned—or \$422.20. Deadline dates for quarterly payments of the estimated tax—including, for the first time, your Social Security tax—are April 17, June 15, Sept. 15, and Jan. 15, 1968. Use Form 1040-ES for filing your declaration of estimated tax.

Bank Credit Cards Tentatively Okayed

You can ethically accept a bank credit card as payment for your service, but you cannot be listed in a credit card directory. There are advantages and disadvantages in these
(Continued on page 308)



IMJ

**SURGICAL
GRAND
ROUNDS**

Case Presentation:

Myocardial Infarction or Pulmonary Embolus?

Edited by JOHN M. BEAL, M.D.

Northwestern University Medical Center

Surgical Grand Rounds are held weekly at 8 a.m.: alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of Surgical Grand Rounds held at Chicago Wesley Memorial Hospital on Sept. 17, 1966.

Dr. Ronald Harrison: The patient is a 64-year-old white male who came to the emergency room because of constricting pain across his lower chest. He stated that the pain was worse on the left than on the right side and had been present for approximately five hours.

The patient had walked three blocks when he had sudden onset of pain. It was associated with marked dyspnea, shallow breathing, and was aggravated by respiration. The patient experienced marked diaphoresis and was markedly apprehensive. He had said that the pain did not radiate to the neck or to either arm and he denied nausea and vomiting.

In the emergency room he received nasal oxygen and morphine and improved promptly. The patient was taking coumadin, digitalis and quinidine.

Review of Systems: The patient had been on limited activity without chest pain although he did have two pillow orthopnea. His weight was stable.

Pertinent Past History: At age 12 or 13 patient had an episode of symmetrical joint pains associated with a sore throat and fever which lasted one month. Shortly thereafter, a heart murmur was discovered which

persisted. The patient had not been told that he had either rheumatic fever or rheumatic heart disease. He had a past history of hypertension of 15 years duration, well controlled by Chlorothiazide (Diuril).

He was hospitalized in April, 1966, with a diagnosis of posterio-inferior myocardial infarction. He was discharged May 15, readmitted on July 9 and treated for congestive heart failure.

Physical Examination: His blood pressure was 155/80; pulse—48 with occasional premature beats and respiration was 18 per minute.

Pertinent Findings: The chest was clear to percussion and auscultation. **Heart:** The first and second heart tones were noted to be unremarkable, there was a grade 3/6 systolic injection murmur heard in the aortic area, apex and transmitted into the neck. Evidence of peripheral thrombophlebitis was not found.

An electrocardiogram was not changed from that obtained in April, 1966, and was not considered to demonstrate myocardial infarction. Serial serum SGOT and LDH levels were normal. The patient experienced several recurrent episodes of chest pain, dyspnea and apprehension following admission, although his vital signs remained stable. Three days after admission lipoheparin was initiated, with a schedule of 15,000 units every 12 hours. Coumadin was continued. A lung scan was obtained using microaggregate radioactive human serum albumin.

Dr. Abram Cannon: This is the initial scan which was made in the anterior-posterior projection. Down at the left base there is decreased perfusion (Fig. 1). The rest looks pretty good. This was repeated

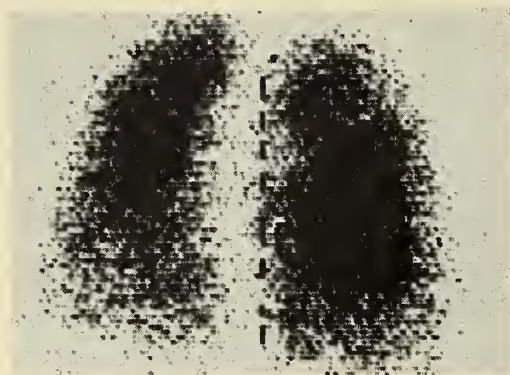


Fig. 1. Perfusion lung scan performed in the prone position using ^{131}I -Macroaggregated Albumin demonstrates decreased perfusion in the lower lobe.

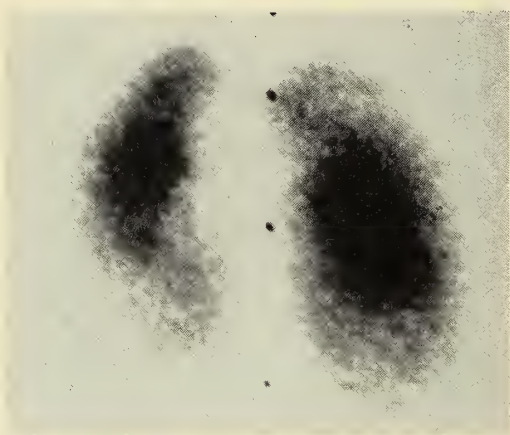


Fig. 2. Repeat study two weeks later, with slightly different technique, demonstrates persistent defect in the left lower lobe. In addition there are new areas of decreased perfusion in the right apex and lower lobe regions.

two weeks later and at this time Dr. Quinn was using a little different technique for spacing patterns. At this time both bases showed decreased perfusion, more on the left side than on the right, but there was decreased perfusion in both (Fig. 2).

Dr. Harrison: Between the time of the two lung scans, the patient had several episodes of pain, tightness in the chest, and dyspnea. An inferior vena cava ligation was performed on the 12th of September. The patient tolerated the procedure well and has had a satisfactory postoperative course. Two days postoperatively he did report hemoptysis, described as rusty brown sputum. For the last three days the patient has been free of chest pain and has felt markedly improved.

The Patient Enters

Dr. John Bergan: The patient appreciates the difficulty in diagnosis of his particular problem. When you had the chest pain, were you having difficulty breathing?

Patient: Yes, I could hardly get my breath.

Dr. Bergan: Could you describe your reaction to these episodes of pain and difficulty in breathing?

Patient: I felt very apprehensive and thought that it was another heart attack.

Dr. Bergan: When Dr. Oschner visited here this past spring, he once again emphasized the association of apprehension with pulmonary embolism. It has been said that an apprehensive postoperative patient should have his vena cava ligated. We would modify that dictum and say that pulmonary embolism should be suspected.

Dr. John Beal: Did the patient have signs of peripheral thrombophlebitis?

Dr. Bergan: No, and this has been true of one-third of the patients at this center needing vena cava surgery for pulmonary embolism.

The Patient Leaves

Dr. Bergan: This case emphasizes the difficulties that may be encountered in the diagnosis of pulmonary embolism and in differentiating it from myocardial infarction. The classical findings of acute onset of chest pain with dyspnea, pleuritic pain and hemoptysis are often absent in patients with pulmonary emboli. The advent of the lung scan has made this diagnosis much easier for us. In our hospital lung scans are used with greater frequency and Dr. Quinn has detected emboli that we did not suspect clinically. For example, in cases of superficial thrombophlebitis of some severity, routine lung scans have shown that there has been an entirely unsuspected pulmonary embolism. This contradicts our past teaching that superficial thrombophlebitis does not cause pulmonary embolization.

Physical examination is often important. A valuable diagnostic sign is the accentuation of the pulmonary second sound in older people. Actually, surgeons usually are called to see patients with pulmonary embolization, when the diagnosis is fairly obvious. Our medical colleagues have faced the dilemma of trying to differentiate a

cardiac problem which should not have operation, from a pulmonary infarct which should have a vena cava interruption to save the patient's life.

From the surgical standpoint, we are now confronted with a choice of operations. A variety of filter operations have been described as well as ligation of the vena cava. Our experience at Northwestern has been reported (Bergan, J. J.; Kinnaird, D. W.; Koons, K. and Trippel, O. H.; Prevention of Pulmonary Emboli, Arch Surg. 92: 605, 1966). We try to individualize an operation for a particular patient without having adequate criteria on which to base individualization. We usually favor a procedure that will maintain patency of the vena cava. However, in patients with multiple discontinuous pulmonary emboli, such as this one, or with pulmonary hypertension, ligation rather than a filter procedure should be performed.

Dr. Beal: Dr. Bergan, this patient had been receiving anticoagulants as part of his treatment for heart disease. Would you comment on the value of anticoagulants in preventing pulmonary embolization.

Dr. Bergan: As in the surgical treatment of peptic ulcer, our operations are reserved for failures of medical management. It is easy to recommend operation for a patient who has emboli when receiving anticoagulant therapy. It is difficult to determine from the large experience reported in literature exactly how frequently this will occur. In medical reports, prothrombin depressants are not differentiated from heparin as a means of anticoagulation, and the effects of one are not at all similar to those of the other. I have estimated that approximately 10 percent of patients with apparent adequate anticoagulation will have recurrent pulmonary emboli.

Another problem that this particular patient presented was the source of the embolization. He did not have peripheral phlebitis and had had a myocardial infarction. The right side of the heart was a potential site of thrombus formation, as were the veins of the pelvis and lower extremities.

Dr. Beal: Dr. Webster, will you comment on the difficulty in differential diagnosis of these patients?

Dr. James Webster: The patient is an excellent example of a man with known heart disease who was adequately anticoagulated

by current standards and yet obviously continued to have thromboembolic episodes. His episode in April was undoubtedly an acute myocardial infarction. In retrospect, the episode of heart failure in July was related to recurrent pulmonary embolization. The clinical picture here is not the classic one taught in medical school; that is, the chest pain is not pleural. Peripheral thrombophlebitis was absent and the chest film was negative.

In patients with pulmonary embolic disease without infarction, the site of origin of the chest pain is unclear. The pain that this patient described probably arose as a result of coronary insufficiency secondary to right ventricle strain. Interestingly enough, it did respond on some occasions to sublingual nitroglycerine. There is also some evidence that such pain may come from acute distention of the pulmonary artery itself.

Once a diagnosis of recurrent pulmonary embolization is made, we are faced with the problem of determining the source of the emboli. As pointed out by Dr. Bergan, the right heart may become filled with clots and perpetuate the problem, so that if we procrastinate, caval interruption is of no value. Accurate antemortem diagnosis of pulmonary embolism is still a continuing source of concern to all of us.

Dr. James Hammond: Would an angiocardigram have been helpful on this man?

Dr. Webster: Angiocardiograms are quite helpful in the first 48 hours after embolism. There are good experimental and clinical studies to indicate that five or six days after the acute episode the chances of seeing anything are relatively small, and certainly we have found that a physician with a high index of suspicion and radioisotope lung scan facilities make an ideal combination for accurate and early diagnosis of pulmonary embolic disease.

Dr. Cannon: I would like to comment on the occasional difficulty in interpreting the lung scans. Areas of bulla formation will produce an area of decreased perfusion. Occasionally unexplained areas of decreased uptake appear. Despite some difficulties in interpretation, lung scans demonstrate numerous changes that are not seen on a chest film. The patient presented today illustrates this point because we did not detect any evidence of pulmonary infarction on our series of films.

Meprobamate Intoxication Treated with Peritoneal Dialysis

By DONALD O. CASTELL, M.D., AND JONAS SODE, M.D.

The fatal potential of meprobamate when taken in excessive amounts has been well documented, with death usually occurring in irreversible shock after prolonged coma. Therapy of acute intoxication is primarily supportive. Recent reports, however, indicate beneficial results from peritoneal dialysis and hemodialysis in severe poisoning.^{1, 2, 3}

It is our purpose to report a case of prolonged coma following ingestion of a large quantity of meprobamate with rapid clinical response to peritoneal dialysis, and to affirm the recovery of the drug in the peritoneal dialysate.

Case Report

A comatose 21-year-old white sailor was brought into the emergency room at 9 a.m. on July 19, 1965. He was found in this condition in his room shortly before admission. A bottle of meprobamate tablets (400 mgm) was near his bed with 25 tablets remaining out of an original total of 100 tablets. He was last seen by his shipmates approximately 10 hours prior to entry into the hospital. Questioning of the patient after his recovery revealed that he had ingested 75 meprobamate tablets about 10 p.m. on July 18 or approximately 11 hours prior to his entry into the emergency room. He had taken no other drugs and had ingested no alcohol.

On admission to the emergency room he was comatose and hyperpneic. Blood

pressure was 100/70. He responded to pain but not to verbal stimuli. The corneal reflex was intact but the pharyngeal reflex was absent. There was no evidence of injury. He was afebrile. Gastric lavage was performed with no return of obvious medication.

Induced Diuresis

Subsequent therapy consisted of induced diuresis with dextrose and electrolyte solutions. Throughout the initial 24 hours of hospitalization the patient's level of consciousness deepened in spite of the above therapy with loss of response to pain. Mild hypotension (90/60) developed necessitating intermittent injections of Aramine. Because of persistent coma and persistent hyperventilation, lumbar puncture was performed 25 hours after admission. The cerebrospinal fluid was completely normal, except for a meprobamate level of 10 mgm percent. Meprobamate concentrations in all fluids were determined by the method described by Berdson.⁴ At the end of approximately 30 hours of hospitalization and 41 hours after ingestion of the tranquilizer the patient remained comatose, with no response to pain and with persistent hyperventilation. At this point peritoneal dialysis was begun.

Improvement Noted in 35th Hour

Dialysis was performed using two liters of 1.5 percent Impersol (Abbott), with a new dialysis started approximately every two and one-half hours; 4 meq KCl/liter was added to the dialysis solution. Alkalinizing agents were not used. A total of six dialyses were performed. Table 1 shows the amount of meprobamate obtained in each dialysis and in simultaneous urine collection. By the 35th hour (5th hour of dialysis) he was showing definite improvement in the level of consciousness with

Dr. Castell is a lieutenant commander in the Internal Medicine Service of the U. S. Navy and Dr. Sode is Chief of the Endocrinology and Metabolism Branch at the U. S. Naval Hospital, Bethesda, Md. This case report is from the U. S. Naval Hospital at Great Lakes, and the opinions or assertions contained herein are the private ones of the authors and are not to be considered as official or reflecting the views of the Bureau of Medicine and Surgery of the Navy Department or the naval service at large.

TABLE 1: THE QUANTITY OF MEPROBAMATE RECOVERED DURING EACH DIALYSIS IS COMPARED WITH SIMULTANEOUS URINARY EXCRETION AND CLINICAL STATUS OF THE PATIENT

Dialysis	Hours After Admission	State of Unconsciousness	Fluid Volume (ml)		Meprobamate Concentration (mg/100 ml)		Total Meprobamate Recovered (mgm)	
			Peritoneal Dialysate	Urine	Peritoneal Dialysate	Urine	Peritoneal Dialysate	Urine
0	30	Coma						
1	32	Coma	2400	135	9.8	171.1	235	231
2	35	Slight response to pain	2300	105	7.3	122.8	168	129
3	37	Responds to painful and verbal stimuli	2400	98	8.8	140.9	211	138
4	39	Eyes open	2400	69	5.9	190.8	142	138
5	42	No change	2300	66	4.5	189.7	104	125
6	45	Awake and talking	2400	63	6.6	222.1	158	140
Total							1018	901

slight response to pain and verbal stimuli. At the end of the 39th hour he responded to verbal stimuli by opening his eyes, and there was definite response to pain. Over the ensuing six hours he became fully responsive and by the 45th hour (15th hour of dialysis), he was awake and talking.

The laboratory studies revealed a urine meprobamate level of 100 mgm percent on admission with negative serum barbiturate, salicylate, and alcohol content. At no time did the patient demonstrate an element of acidosis, and in fact arterial pH values of 7.42 (25th hour) and 7.48 (36th hour) were obtained.

Discussions

Previous reports have documented suicidal deaths after ingestion of 12-47.6 gms of meprobamate with circulatory collapse occurring up to 5 days after ingestion.^{5, 6, 7} The patient reported here ingested 30 gms of this drug, and although he showed only mild hypotension, prolonged coma was present, which did not improve until after peritoneal dialysis was initiated.

The ability of meprobamate to readily diffuse across the peritoneal membrane was originally demonstrated in laboratory animals, in which intraperitoneal injections of this drug resulted in excellent absorption.⁸ It is therefore not surprising that peritoneal dialysis should be effective in removing sufficient amounts of this drug from the blood stream. There are only two previously reported cases of the successful treatment of meprobamate intoxication by this method,^{1, 2} and in only one of these were drug levels in the peritoneal dialysis obtained.² Although the total quantity of

meprobamate recovered in the peritoneal dialysate of our patient was modest, the rapid clinical improvement after a long period with no improvement prior to dialysis gives much support to the effectiveness of peritoneal dialysis in treatment of severe meprobamate intoxication. Although this drug is well excreted by the kidneys, forced diuresis may not be feasible in cases complicated by persistent hypotension.

Summary

A case of meprobamate intoxication is reported showing clinical response with peritoneal dialysis. Analysis of the peritoneal dialysate revealed recovery of ample quantities of the drug.

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Case Report:

Malrotation of the Intestine, Volvulus and Gangrene with Survival

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AND WILLIS J. POTTS, M.D. / CHICAGO

This is a report of a 21-month-old female with an acute episode of malrotation, volvulus and gangrene that required extraordinary surgical and medical efforts to save the child's life because of the many complications that ensued.

The case is also presented to encourage a vigorous and aggressive approach to the problem of volvulus with massive bowel gangrene in infants and children.

Case History

On May 17, 1963, K. C. was admitted to this hospital for the first time, with a 24-hour history of cramping abdominal pain and vomiting. During the 12 hours prior to admission she became increasingly lethargic and febrile, and abdominal distention was noted. A loose stool was passed 18 hours prior to admission, but there was none subsequently.

The birth and early history were normal until seven months prior to admission, at age 14 months, when the infant began to have loose, frequent (five-eight per day) foul smelling stools, and she became an irritable, demanding infant. There was no previous history of gastrointestinal disease or allergy. During the ensuing months investigation revealed normal blood count, urinalysis, sweat test, stool trypsin, pH, and

cultures, and microscopic examination of stools for fat and starch granules.

It was our clinical impression that she had a gluten hypersensitivity, and her stools as well as her personality improved dramatically when a gluten-free diet was prescribed. One month prior to admission she had a six-hour episode of crampy abdominal pain which was alleviated with belladonna.

Admitted to Hospital in Shock

When admitted to the hospital, the patient was in shock. Rectal temperature was 102.6° F., pulse 200/min. and thready, respirations 40/min. and systolic blood pressure 35 mmHg by flush technique. Her weight was 24 pounds (25th percentile) and height 32 inches (20th percentile). She was obtunded and unresponsive. Examination of the ears, nose, throat, lungs, heart and genitalia was normal. There were no meningeal signs. The abdomen was distended, tense and tender, with absent peristaltic activity. A firm plum shaped mass was palpable on rectal examination. The initial impression was that she had an intra-abdominal catastrophe with shock.

Initial laboratory studies were: serum sodium 137 mEq/L, chloride 114 mEq/L. Hemoglobin 15.3 gm%, hematocrit 46%, WBC 10,600 with 65 polys and 3 bands.

Laparotomy Performed

Following barium x-ray studies, it was felt she had malrotation with midgut volvulus, and a laparotomy was performed four hours after admission. On opening the abdomen malrotation of the colon was seen with small bowel volvulus of more than 360 degrees. The bowel was gangrenous approximately 18 inches below the ligament

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of Treitz to eight inches above the ileocecal valve. Despite the patient's desperate condition, resection of the gangrenous small bowel was performed and an end to end anastomosis was accomplished. An incidental small bowel duplication was found located near the proximal line of resection measuring 5.0 x 3.0 x 1.5 centimeters (Fig. 1). Pathological report was as follows:

The gross specimen consists of a 200 cm. segment of small bowel still retaining its tightly coiled pattern and having intact mesentery. The bowel is slightly dilated throughout and exhibits a bluish-pink discoloration; 5.0 cm. distal to the jejunal line

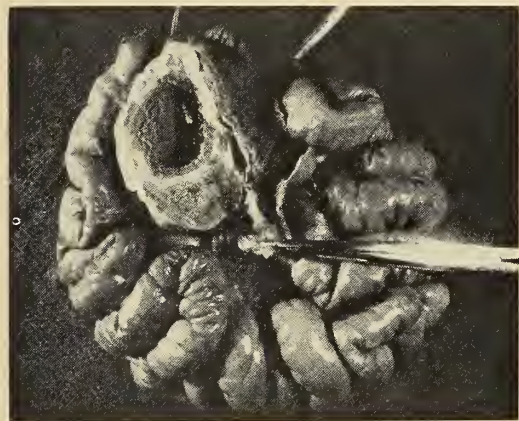


Fig. 1. Resected small bowel: duplication near proximal line of resection. A probe passes from bowel lumen into the central cavity of the duplication.

of resection, a firm rubbery discoid mass measuring 5.0 x 3.0 x 1.5 cm. is situated within the mesentery and adherent to the mesenteric aspect of the proximal jejunum. On opening the adjacent bowel in this region a small 0.2 cm. mucosal orifice is noted on the mesenteric side through which a probe can be passed into a central cavity of the mass described. The mass on section has a central cavity lined by partially necrotic mucosa and supported by a thick muscular wall. The mucosal pattern of the bowel elsewhere has a slight brownish discoloration.

Necrosis at Small Bowel

Microscopic sections through the discoid mesenteric mass reveal its cavity to be lined by partially necrotic gastric mucosa. There is a well defined muscularis which forms a wall in common with the adjacent jejunum at its site of contact. Sections through the proximal and distal sites of bowel resection reveal superficial mu-

cosal congestion and focal necrosis, whereas sections through the mid-loops of small bowel reveal hemorrhagic congestion and necrosis of the entire wall. The mesentery is greatly congested, but no thromboses are noted.

Diagnosis: 1. Venous stasis with necrosis of small bowel, consistent with volvulus.

2. Duplication of jejunum.

During the operation the patient was in deep shock, and during the ensuing 36 hours large amounts of parenteral fluids, including plasma, were necessary to combat profound hypovolemia. Antibiotics were administered.

Peritonitis Develops

Six days post-operatively a limited liquid diet was started. By the following morning it was apparent that peritonitis had developed. Pneumoperitoneum was not present. On re-opening the abdomen extensive peritonitis and two large perforations of the small bowel were found adjacent to the anastomosis. An additional 8-10 cm. of small bowel encompassing the previous anastomosis were resected, and another end to end anastomosis performed.

Following this, she did relatively well and was gradually weaned from intravenous fluids. During the next four weeks thrombophlebitis occurred in the left leg, and a small left lower quadrant mass was palpated in the area of the incision. This mass was probed through the lower end of the previous incision and a very small amount of clear fluid returned. A few days later this mass became fluctuant. When it was incised, 10 cc. of blood-tinged purulent material was obtained. Ten days later a small bowel-cutaneous fistula was evident, with the fistula draining 600-1000 cc. per 24 hours. Sump drainage of the two cutaneous openings plus intravenous feedings were continued for one week, but operative interruption of the fistula became imperative.

Jejunocecostomy Performed

Thus, a week later surgical exploration was performed. The bowel fistula was found with difficulty, just proximal to the ileocecal valve. Because of the edematous tissues, ileocecal valve by-pass, using a jejunocecostomy, was performed. To facilitate continuous decompression of the precarious

area of the new anastomosis, the appendix was exteriorized and a plastic catheter was inserted through the appendix into the bowel at the region of the anastomosis.

Six days later oral fluids were instituted, most of which came out through the appendicostomy tube. The following day the patient began to pass blood through the appendicostomy tube and per rectum. The appendicostomy tube was withdrawn in the hope that the bleeding was due to the tube erosion of the mucosa and not anastomosis breakdown. Within the next 24 hours, 750 cc. of whole blood was needed to replace the losses and prevent shock. Within two days the bleeding had ceased, and 10 days later the child was taking frequent feedings orally, resulting in a surprisingly low number of daily stools (seven-10).

Intravenous Therapy Complicated

Intravenous therapy was extremely complicated and included large amounts of plasma and whole blood, plus salt-free albumin. Lipomul-IV® was used on several occasions. Steroids (Solu-Cortef)® were also used in large doses during the initial phase of endotoxic shock. At one time or another, the patient received massive doses of Penicillin, Chloramphenicol, Sodium Methicillin, Kanamycin and Sulfadiazine. She was discharged weighing 18 lbs. on Aug. 4, 1963, eating a general diet.

During the next two months she had two episodes of adynamic ileus with dehydration following short periods of vomiting and diarrhea. Both episodes responded readily to intravenous fluids. It was also during this two-month period that a peculiar recurring phenomenon was noted. This phenomenon consisted of fairly rapid onset (within hours) of lethargy, bizarre and aggressive, almost psychotic behavior, abdominal distension and diminished peristaltic bowel activity. Fever and vomiting were absent. Within 24 hours, and always following the passage of a voluminous, foul-smelling stool, the patient returned to normal. During the 12 months following hospitalization these episodes became less frequent and less severe.

Unusual Features Listed

At age three years she was doing well on an unlimited diet and without medications. She weighed 27 pounds and was 35½ inches tall (7th percentile for weight and height).

At three and one-half years she was 30 pounds. Clinically she was well until July 1963, when she developed a mild glomerulonephritis which responded to conservative treatment. In August, 1965, (age 4 years) she was still 30 pounds, but was 38½ inches tall.

The unusual features of this case are:

1. The suggestive evidence that the patient's initial symptoms were due to a gluten sensitivity.
2. Malrotation of the cecum with a 360° volvulus and massive small bowel gangrene.
3. Anastomosis of the bowel, by-passing the ileocecal valve.
4. The presence of a communicating small bowel duplication.
5. Multiple complications including post-operative small bowel perforation with peritonitis; ileo-cutaneous fistula; pelvic abscess; thrombophlebitis, urinary tract infection, and a megaloblastic hematologic picture, plus hypogammaglobulinemia.
6. A post-operative "dumping-like" syndrome with bizarre behavior.

Discussion

In this child the manifestation of gluten hypersensitivity on an unrestricted diet, were frequent (six-eight/day), bulky, foul-smelling stools that floated; many fat droplets were observed. In addition, the patient's general behavior was that of an irritable, demanding and unhappy child. There was marked behavior change (happy and pleasant) when a gluten-restricted diet was prescribed. This diet also produced a significantly different stool pattern: two to three per day, soft, not particularly odoriferous and without the greasy character noted while receiving an unrestricted diet.

Malrotation occurs embryologically when the midgut (i.e. the intestine from the duodenum to the mid-transverse colon) fails to complete its counter-clockwise rotation when returning to the abdominal cavity from the umbilical cord.^{1, 2} When the rotation of the cecum is incomplete, the mesenteric attachment of the midgut to the posterior abdominal wall is not completed, and the midgut hangs on a pedicle (which contains the superior mesenteric artery) and this unattached pedicle predisposes to volvulus of the small intestine.¹

Malrotation may present a clinical pic-

ture of celiac syndrome or gluten sensitivity,^{3, 4, 5, 6} especially if intermittent obstruction results in interference of venous return of the small bowel vasculature. However, not all anatomic malrotations give symptoms.⁷ In older children, especially those with the vague history of intermittent abdominal cramps, associated with or without vomiting and loose stools, a barium enema revealing malrotation may be the only positive finding after a long series of normal diagnostic procedures. Therefore, we recommend a barium enema be done early in the evaluation of such a child. In infants under one year of age, an upper gastrointestinal contrast examination with small bowel follow through is usually more valuable, since it may well reveal the level of an obstruction, whereas the barium enema may only confirm a diagnosis of malrotation.

Volvulus may be associated with malrotation in 50 percent of cases.^{4, 7, 8, 9} The degree of volvulus is variable, but those with 180 degrees or more of twist result in a much higher percentage of small bowel gangrene.⁴ In infants and children, strangulated hernia and midgut volvulus are the commonest predisposing causes of small bowel gangrene.¹⁰

Intestine Length Variable

The length of small intestine in infants and children is apparently quite variable and not very well studied. Between 12-24 months of age the small intestine may vary from approximately 320 to 645 centimeters, averaging 453 centimeters.¹¹ The small intestine length decreases 30-40 percent when fixed in formalin.¹⁰ In this patient the measured resected segment of small intestine was 150 centimeters in the formalin fixed state. Although the remaining small intestine was not measured, the resection was estimated to be approximately 70 percent.

Most investigators stress the importance of the length of small intestine remaining after resection, and which segment remains, when evaluating the prognosis of a child following massive resection.^{12, 13} Compensatory hypertrophy and hyperplasia of villi may result in as much as a 400 percent increase in surface area of the remaining small bowel.^{12, 14} A delay in stomach emptying, and a decrease in motility of the small bowel seems to occur, and "intestinalization of the proximal right colon may

also occur.^{15, 16}

Loss of the ileocecal valve leads to increased water losses, and in dog experimentation, the loss of the ileocecal valve appears to have its greatest consequences on the nutritional adjustments after large segments of the distal small bowel have been resected, and less consequences on these adjustments if only proximal bowel has been removed.¹⁷ For example, if 50-70 percent of proximal small bowel is removed, protein and fat absorption are not significantly altered and weight is maintained. However, if 50 percent of distal small bowel is sacrificed, profound interference with fat absorption occurs and weight loss results.^{14, 17}

Gastrointestinal duplication is an uncommon anomaly, and there is no common clinical pattern of signs and symptoms for the recognition of duplication.¹⁸ In one series of 38 patients who had a variety of bowel duplications, 10 had the duplication discovered when they had surgery or investigation for other problems.¹⁸ Occasionally, a duplication may communicate with adjacent bowel, and when distention and increased pressure of the pouch occur, a palpable mass may be felt. Obstruction resulting from a distended communicating duplication has been reported, but is rare.⁷ In our patient the communicating duplication was an incidental finding at surgery and did not appear to be a factor in the obstruction.

Further Surgery Necessary

Perforation with extensive peritonitis closely following massive resection for infarcted bowel has an attendant high mortality. The two perforations found in this patient were in an area very near the ileocecal valve, in a segment of bowel in which complete viability was questionable when the initial anastomosis was performed. Because of the child's critical condition during surgery, and the known importance of the terminal ileum, this terminal segment was not resected. Subsequently, the terminal ileum was too short for any jejunoileal anastomosis and therefore the jejunum was anastomosed, end to side, to the cecum, just above the ileocecal valve.

The most difficult complication encountered was an ileo-cutaneous fistula which began to drain large amounts of fluid during the seventh week of hospitalization. Electrolyte solutions, whole blood, plasma, albumin, and Lipomul-IV® were used in

large quantities in order to maintain the patient's fluid and electrolyte equilibrium. When she was reoperated on (for the fourth time in seven weeks) a huge small bowel fistula at the site of the previous anastomosis was found. At this time the ileocecal by-pass was performed.

Urinary Tract Complications

During part of the prolonged hospitalization and especially during the complicated intravenous therapy an indwelling bladder catheter was used. It was not until after removal of the catheter, however, that any urinary tract complication was encountered. Pyuria, bacteriuria, and fever elevations were found to be due to an overgrowth (greater than 100,000 organisms per cubic centimeter) of *Aerobacter aerogenes*, which was successfully treated with Furadantin.®

Transient hypogammaglobulinemia was noted during hospitalization and for a short time after discharge, three separate determinations revealing levels of 140, 210 and 103 mgm%. She received plasma and gamma globulin while in the hospital, and then monthly gamma globulin injections for approximately one year following discharge.

A deficiency in serum gamma globulins can result either from a failure in the synthesis of these proteins or from an increased rate of loss from the circulation without an increase in the rate of synthesis.¹⁹ The gamma globulins appear to be synthesized in the cells of the lymphoid system.¹⁹

Megaloblastic Anemia

The transient nature of the condition was felt to be secondary to the prolonged catabolic physiologic state she experienced, and the massive bowel resection which resulted in the loss of a large amount of lymphoid tissue.

A megaloblastic anemia associated with peripheral macrocytosis and hypersegmented neutrophils is a frequent concomitant complication of intestinal fistulas, strictures, and anastomoses following small bowel resection.^{20, 21} The rapid transit time with diarrhea, and an altered intestinal flora results in losses of vitamin B₁₂ folic acid and iron that might otherwise normally be absorbed. Folic acid is absorbed chiefly in the jejunum and vitamin B₁₂ mainly in the distal ileum, and in cases of massive small bowel resection megaloblastic anemia often develops, but sometimes not until several

years after operative resection,^{21, 22} therefore, parenteral folic acid and vitamin B₁₂ are advised. This patient exhibited these peripheral characteristics, and although a bone marrow study was not performed to confirm a megaloblastic change, vitamin B₁₂, folic acid and liver extract were given parenterally monthly for 18 months and have been continued intermittently.

Summary

A case report of malrotation initially presenting as gluten-induced enteropathy has been presented. The management of the acute volvulus with gangrene, with eventual survival, following multiple complications was a concerted team effort of medical, surgical and nursing cooperation. Various aspects of this multifaceted case have been reviewed, and follow-up progress has been offered. We wish to support and recommend a vigorous and aggressive approach to the problem of volvulus with massive bowel gangrene in infants and children.

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The Early Diagnosis and Treatment of Allergic Asthma

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The diagnosis of allergic asthma depends on history, physical examination and only a few ancillary laboratory examinations. Allergy skin testing does not diagnose allergic disease. It only helps us to determine what the allergic disease is caused by. The patient should never be skin-tested for allergens until it is determined that he is allergic.

Symptoms

Bronchial asthma may be defined as a form of obstructive emphysema involving both lungs throughout, characterized by paroxysmal attacks of dyspnea, accompanied by wheezing, chiefly expiratory, heard on auscultation of the chest and typically relieved, at least in the early stages of an attack, by sympathomimetic drugs.

However, there are usually several other things going on which help one in making the diagnosis. Frequently the patient starts out with what he calls a cold. Actually, what the patient means is that he starts out with some nasal congestion, watery rhinorrhea, sneezing, and itching of the nose. This progresses into a cough, itching of the throat, a feeling of tightness in the chest, progressing on into definite wheezing. Most patients will have the nasal symptoms if you ask them about it. In addition, most patients have some itching. Itching is one of the prime symptoms of allergic disease. If the patient does not have itching, it is unlikely that the symptoms are allergic. If he does have itching, it is much more likely that the symptoms are allergic in origin. Patients with allergic asthma will dig at their throat because of itching. They may have itching of the nose, itching of the

ears, itching of the palate, itching of the throat or itching of the neck.

Prolongation of the expiratory phase is a usual objective finding; however, the patient seldom realizes that he is having difficulty getting air out. Usually he feels he cannot get enough air into his lungs.

Temperature elevation is not a part of atopic disease; therefore, a patient with allergic asthma does not have an elevated temperature unless he has secondary infection. The patient usually feels well except for the shortness of breath and difficulty breathing. There is no malaise, muscle aches or pains or generalized systemic effects. Usually, once the attack has abated the patient feels perfectly well.

Signs of Allergic Asthma

Though the patient may not complain of any nasal symptoms, the nasal mucosa usually is pale, boggy, bluish and edematous with some increase in secretions. The nasal mucosa is a representative area of the respiratory tract and advantage should be taken of its ready accessibility to inspection. A head mirror with a nasal speculum is the only way to look at the nasal mucosa. An otoscope with a nasal attachment discolors the mucosa and masks the usual appearance. In addition, it does not open up the nares enough to allow one to see the posterior part of the nasopharynx, or the middle and superior turbinates.

Of prime importance in allergic asthma is that the wheezing is both in inspiration, as well as expiration. A patient who has only expiratory wheezing is unlikely to have allergic asthma.

Laboratory

Most of the laboratory studies are to rule out other diseases rather than to actually diagnose allergic asthma. Two lab-

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oratory procedures can be extremely helpful in making the diagnosis of allergic asthma. One is the nasal smear for eosinophils. When positive, this is a strong indication of allergic disease. The other is a sputum examination for evidence of Kirschman spirals, mucus plugs and eosinophils. These are two, easy, cheap, and simple examinations that can be performed by any laboratory or by the physician in the office and can lend valuable information in the diagnosis of allergic asthma. On gross examination the sputum from an allergic person is usually clear or white in color. Its consistency ranges from foamy to rather thick and gooey. Purulence and color such as green or yellow are substantial evidence of infection. Thin, foamy sputum is good evidence that the patient is well hydrated. Thick, gooey sputum is good evidence that the patient is dehydrated.

X-rays of the chest and sinuses are helpful to rule out infection, foreign body and other forms of complicating disease. The urine specific gravity furnish further information concerning the state of hydration of the patient. With the history, physical examination and the above laboratory studies, it should be possible to determine whether or not the patient has allergic disease.

The treatment of allergic asthma is best approached in two phases:

One, the treatment of the acute attack and two, the long term or prolonged treatment. The outlined treatment here presupposes that a history, physical examination and laboratory studies have been accomplished and a diagnosis of allergic asthma has been established. Also, all complicating factors such as pneumonia, foreign body, tuberculosis, and fibrocystic disease, have been ruled out or are receiving appropriate therapy.

The treatment of an acute allergic asthma attack is outlined in Fig. 1. If the patient does not respond to these simple medications, he has one or more of the factors listed in Fig. 2.

Clues as to secondary infection are elevated temperature, purulent sputum, physical findings of moist rales or signs of consolidation on physical examination. Chest x-ray and CBC help to rule out or establish infection. The state of the hydration of the patient can be determined by examining the patient's mucus membranes and skin

TREATMENT OF THE ACUTE ASTHMA ATTACK

1. SYMPATHOMIMETICS: a. AQUEOUS EPINEPHRINE 1:1000
0.2 TO 0.5 cc SUBCUTANEOUSLY
MAY BE REPEATED q 15 MIN.
b. SUS-PHRINE 0.2cc SUBCUTANEOUSLY
2. THEOPHYLLINE: THREE TO 3½ MG / KG / DOSE. SHOULD NOT BE GIVEN UNDILUTED OR RAPIDLY I.V.
3. FLUIDS - THE PATIENT MUST BE HYDRATED OR MEDICATION WILL NOT BE EFFECTIVE
4. INTERMITTENT POSITIVE PRESSURE WITH ISUPREL 0.3cc AND 3cc SALINE

Fig. 1

CAUSES FOR FAILURE OF ACUTE ASTHMA TO RESPOND TO TREATMENT

1. INFECTION
2. DEHYDRATION
3. OVERWHELMING DOSE OF ANTIGEN

Fig. 2

turgor, by the consistency of the sputum, and by the urine specific gravity. If the patient is dehydrated, simple hydration many times will alleviate an attack. Oral fluids will sometimes suffice but a quicker and more scientific way is to give intravenous fluids. A hypotonic, multielectrolyte solution is preferable. A solution that contains 75 mEq of sodium, 60 mEq of chloride and 10 mEq of potassium per liter is most commonly used. Give the patient about 25 to 30 percent of his calculated 24-hour fluid requirement over a two-to-three-hour period. If the patient continues to have symptoms after this, an additional dose of epinephrine will usually suffice to cause remission of the symptoms.

Treatment of the patient with infection or with severe, unremitting asthma, due to an overwhelming dose of the antigen is an individual proposition and cannot be handled in a short paper such as this. If the patient responds partially to the epinephrine or aminophylline or a combination of the two, many times the symptoms can be completely eliminated by giving the patient intermittent positive pressure, using an aerosol of 1:200 Isuprel,

3/10 cc; and 3 cc of saline, Alevoire, or propylene glycol for 20 minutes.

Long Term Treatment

The overall long term treatment of the allergic asthmatic can be divided into four areas: (1) avoidance; (2) symptomatic therapy; (3) hyposensitization; and (4) general care of the patient. Avoidance of the offending allergens is obviously the best way to treat or prevent allergic disease; whenever a specific allergen exists which can be reasonably avoided or at least reduced in the environment, this should be undertaken.

Unfortunately, the vast majority of allergens cannot be avoided. Pollen and mold spores float in the air as far as several hundred miles depending on prevailing winds and air currents. Bermuda grass pollen has been found in the middle of the Pacific Ocean. It is therefore neither wise nor helpful to tell a patient to avoid pollen since the patient cannot possibly do this and live within our normal environment. To tell the patient to avoid something which he cannot possibly avoid is actually harmful since it is frustrating and discouraging to the patient. Such things as feathers, animal danders and specific foods to which the patient is known to be allergic can be easily avoided and this should be done.

Control Bedroom Dust

Certain materials such as house dust cannot be completely eliminated from the patient's environment but effective measures can be taken to reduce his total exposure to the material. All the surroundings of the dust sensitive patient should be as free as possible from dust of any kind. Most people cannot control the dust conditions under which they work or spend their daylight hours but everyone, to a large extent, can eliminate dust from the bedroom. Another simple procedure which can help reduce the exposure to dust, pollen, mold spores and other inhalants is to have the person brush his hair very well before he goes to bed at night in another room other than the bedroom. Hair collects these materials during the day and when the patient lies down at night the pollen and allergens drop off the hair onto the pillow and the patient breathes them in. Frequent washing of the hair and elimination of oil or grease from the hair will also help reduce the exposure to these inhalants.

Contrary to popular procedure, foods which are known to be frequently allergenic should not be eliminated from a person's diet on general principles. It is quite common to see a child who has had some allergic disease such as asthma, have chocolate, seafoods, eggs, nuts, and even milk eliminated from the diet for no specific reason other than some of these foods might possibly have some relationship to allergy. Eliminating these, when a person is not allergic to them, does absolutely no good in the care of the patient and can create many psychological problems, both immediate and future.

Symptomatic Therapy: There is no simple recipe for symptomatic treatment of allergic disease. What works for one patient does not necessarily work for the next. This is where we get into the art of medicine and not the science. However, there are some simple rules of thumb which have been quite helpful in Fig. 3.

GUIDES FOR SYMPTOMATIC THERAPY OF THE ALLERGIC ASTHMATIC

1. HAVE MEDICATION ON HAND SO THAT IT CAN BE STARTED AT FIRST SIGN OF SYMPTOMS
2. FIT MEDICATION TO PATIENT AND NOT PATIENT TO MEDICATION
3. TEACH THE PATIENT ABOUT THE MEDICATION AND HOW TO USE IT
4. SET LIMITS ON MEDICATION AND HAVE PATIENT ADJUST MEDICATION WITHIN THESE LIMITS
5. SET UP A DEFINITE PROGRAM FOR PATIENT
6. USE ONLY THOSE MEDICATIONS FOR WHICH THERE IS A DEFINITE NEED

Fig. 3

The standard medications for the treatment of allergic asthma are listed in Fig. 4.

Hyposensitization as used in allergic diseases is an immunologic procedure which is based on the theory that the antibody response of an animal to an antigen varies with the route of administration of the antigen. The natural route of administration of inhalants and pollens is the respiratory mucus membrane which stimulates certain susceptible individuals to develop skin sensitizing (allergic, atopic or reagenic) antibodies. By giving the same antigen intracutaneously, subcutaneously, or intramuscularly, an immunity is developed. The development of blocking antibodies is a known response and there are probably others which at the present time are not defined. At any rate, the response to hyposensitization acts in all respects, like an

STANDARD MEDICATIONS USED IN TREATMENT OF ASTHMA

- | | |
|----------------------|-------------------------|
| 1. SYMPATHOMIMETICS: | 3. EXPECTORANTS: |
| a. EPINEPHRINE | a. IODIDES |
| b. ISOPROTERINOL | b. GLYCERYL GUAIACOLATE |
| c. EPHEDRINE | |
| d. PSEUDOEPHEDRINE | 4. SEDATIVES |
| 2. THEOPHYLLIN | 5. FLUIDS |

Fig. 4

immunologic response and not a medical or pharmacological response. Although the results from hypersensitization are not as uniformly good as we would like, it is the only way we have of changing an individual's response to his allergens. Hyposensitization with avoidance and symptomatic therapy, will help 90 to 95 percent of your asthmatics. When looking for benefit from hyposensitization, don't look for a cure or any dramatic change. Look for the patient to have less trouble, less often and when he does have his asthma, it is milder and more easily controlled with symptomatic medication.

Physical Exercise Program

In addition to avoidance, symptomatic therapy and hyposensitization, the general care of the patient is important. Asthmatics should have a good physical exercise program. Good pulmonary hygiene is, of course, always an important aspect. Hydration, expectorants, postural drainage, proper methods of coughing, and breathing exercises are all important ancillary treatments. Collateral illnesses should always be handled and watched for. Excessive fatigue should be avoided. Chilling will cause

increased difficulties with asthma. A good rounded diet is important. Fadism, avoidance of foods that give no difficulty and dietary extremes are all to be avoided.

Physiological factors influencing allergic asthma are important because they increase the patient's symptoms. Psychological factors are never the primary etiology of asthma, but on the other hand play a significant role in every asthmatic patient.

It should be explained to the patient that anxiety is a usual response to asthma and that emotional problems make asthma worse by normal physiological processes. Many patients have been told their disease is all emotional. They then believe that there is something drastically wrong with their psyche and this in turn causes more anxiety which is followed by an increase in their asthmatic symptom. Once the patient recognizes that his emotional response to his disease and his disease response to his emotional stimuli are normal factors which are to be accepted, understood and supported, a great burden is lifted from the patient's shoulders.

Summary

Allergic asthma can frequently be recognized early by its typical paroxysmal dyspnea and wheezing with the presence of itching, clear secretions and lack of febrile response. Early and prompt treatment with sympathomimetics such as ephedrine or epinephrine, plus adequate hydration, usually is sufficient to abort or break up an attack. A plan of home therapy is an important part of the management of the patient. The prolonged management of the asthmatic involves avoidance, symptomatic therapy with a definite plan, hyposensitization and good general care of the patient.

Socio-Economic News

(Continued from page 293)

credit plans—explore them thoroughly before agreeing to participate.

Social Security and Retirement Planning

Don't overlook the Social Security benefits owed to you in planning your retirement program. An outline of the benefits—including explanations of such terms as "fully insured," "currently insured," "quarter of coverage," and "lump sum payments"—is available upon request from the Division of Public Relations and Economics, ISMS, 360 N. Michigan Ave., Chicago 60601.

—By GAYLEN LAIR AND MARVIN SCHRODER

Wounds and Injuries of the Kidney

B. G. CLARKE, M. D. / PEORIA

Renal trauma is properly suspected in any case of severe injury to the flank, upper abdomen or lower thorax and in every patient with an open wound in these parts of the body. Gross or microscopic hematuria are usually but not always present (Table 1). The renal artery or the ureter can be either avulsed or blocked with the result that no blood appears in the urine.

Intravenous pyelograms can and should

the thorax (Table 2). Prompt exploration is needed and the results are good (Table 3). Three-quarters or more of wounded kidneys can be preserved by suturing or packing, with drainage (Fig. 1). An ample abdominal or thoraco-abdominal incision allows repair of injuries of other viscera as well as the kidney.

Non-penetrating wounds are often self-limiting (Table 4). Fig. 2 exemplifies such

TABLE 1
INJURIES OF KIDNEY
PHYSICAL SIGNS AS RECORDED

	Peoria*	New Haven	New York (Orkin)	Pittsburgh
Gross hematuria	66%			76%
Microscopic hematuria	74%			96%
Flank tenderness	75%	51%		
Generalized abdominal tenderness	7%	28%		
Palpable flank mass	10%	17%	33%	9%

* 10-year survey, Methodist and St. Francis Hospitals, Peoria.

be made in every case of suspected renal or ureteral injury while the patient is on the table for emergency x-ray study of associated fractures and other injuries. The patient does not need to be moved and continues to receive treatment for blood loss and shock during the few minutes required for intravenous pyelograms. These provide critical information as to whether or not a normal kidney is present. Intravenous pyelograms may be of good enough quality to define with exactness the extent and type of renal damage.

Penetrating wounds of the kidney are nearly always associated with penetrating wounds of other abdominal viscera or of

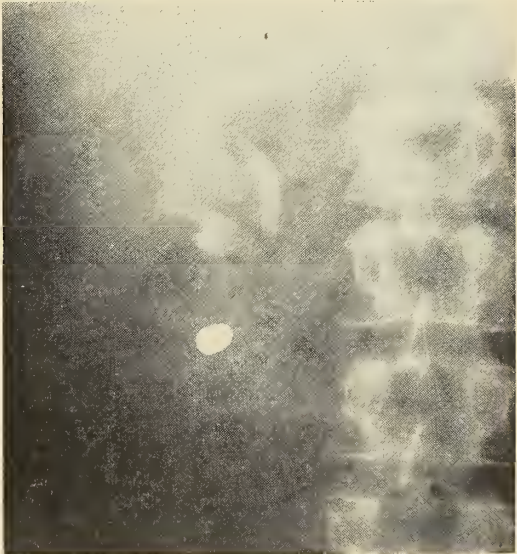


Fig. 1. Through-and through gunshot wound of lower pole of kidney, treated by immediate laparotomy and suturing; intravenous pyelogram four days later (SF 202812).

From the Department of Urology, Northwestern University Medical School, Chicago, and from Methodist and St. Francis Hospitals, Peoria. Presented at postgraduate seminar sponsored by the North Central Section, American Urological Association, Inc., Sheraton Hotel, Columbus, Ohio, Oct. 30-Nov. 1, 1966.

TABLE 2
PENETRATING INJURIES OF KIDNEY
ASSOCIATED INJURIES

	Intraperitoneal	Thoracic
World War II (collected)	59%	20%
Houston	80%	—
Viet Nam, U.S. Forces, 8/65-4/66	100%	—
Dallas (Peters)*	80%	—

* P. C. Peters: Symposium on Genito-urinary Tract Trauma, A.M.A. Section of Urology, Chicago, June 30, 1966.

TABLE 3
PENETRATING INJURIES OF KIDNEY
SALVAGE RATE OF KIDNEYS AFTER
EARLY EXPLORATION

	Per cent
World War II (collected)	73
Houston	77
Viet Nam, U.S. Forces, 8/65-4/66	91

TABLE 4
NON-PENETRATING INJURIES OF KIDNEY:
PROPORTION OF CASES CLASSIFIED AS
"MINOR" AND PRESUMABLY
SELF-LIMITING

City	Per cent "minor"
Milwaukee	58
Baltimore	66
Providence	76
New Haven	65
Houston (including moderately severe)	89
Peoria	73

TABLE 5
INJURIES OF KIDNEY
REPORTED SEQUELAE

Secondary hemorrhage; stricture; fistula; infection; pyonephrosis; hydronephrosis; cystic calcification; thrombosis of renal artery; renal atrophy; post-traumatic cyst; capsular hydrocele; perinephric abscess; renal ("Goldblatt") hypertension; arteriovenous fistula

a case with full recovery. In cases of more severe injury considerable residual renal damage may result (Fig. 3). The complications of more severe non-penetrating renal injuries are many (Table 5), and their rate of incidence high (Table 6).

After severe renal injury massive hematoma formation, pressure necrosis of the renal cortex, inflammation due to extravasated urine, and sepsis are likely to appear. Operative repair of the kidney becomes more difficult or impossible and

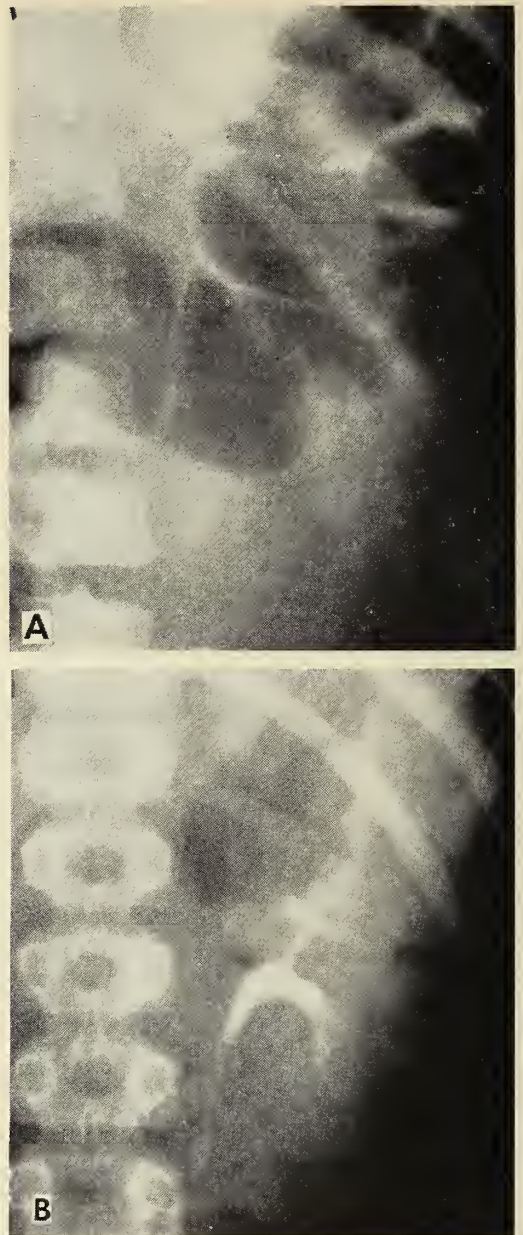


Fig. 2. Intravenous pyleogram four days (A) and two months (B) after non-penetrating injury in a 10-year-old boy from a fall (M 217126).

nephrectomy more hazardous under these conditions, as time passes.

Prompt decision as to which patients with non-penetrating injuries of the kidney need operation is therefore necessary. An excretory urogram done immediately after the accident may give enough information to permit making such a decision with confidence. If surgery is not chosen, bed-rest, blood replacement, sedation, antibiotics and close observation are the mainstays of

TABLE 6
NON-PENETRATING INJURIES OF KIDNEY
CLASSIFICATION "MAJOR"
SEQUELAE OF SUPPORTIVE-EXPECTANT
TREATMENT

City	Number of cases	Number with serious sequelae
Milwaukee	70	9
Providence	12	5
Houston	7	5
Peoria	8	5



Fig. 3. Retrograde pyelogram one year after severe non-penetrating injury sustained in an automobile accident (M 205802).

treatment. Injuries outside the genito-urinary system are common (Table 7), and if severe enough may weigh heavily in favor of non-operative treatment.

Drip-infusion pyelography, which results in dense opacification of the renal cortex, may define renal lacerations precisely. The highly concentrated dye may demonstrate extravasations clearly. Drip-infusion pyelograms therefore should be considered in any patient in whom conventional excretory urography does not permit prompt decision as to whether or not operative repair of the kidney is needed. Renal angiography (Fig. 4), retrograde pyelography, or renal photoscanning may also be useful. Unlike drip-infusion pyelograms, these examinations require special equipment and experienced operators. All are likely to be of most value if done soon after injury.

At operation for a non-penetrating injury of the kidney, adequate exposure is es-

TABLE 7
NON-PENETRATING INJURIES OF KIDNEY:
ASSOCIATED INJURIES OF OTHER
SYSTEMS

City	Per cent
12th General Hospital	50
Peoria	10
New York (Orkin)	70
New Haven	16
Los Angeles	81
Columbus	25
Dallas (Peters)	10

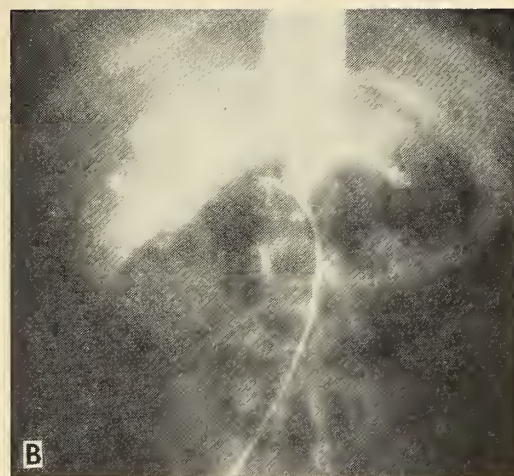


Fig. 4. Selective renal angiogram in a 3½-year-old boy four days after a fall. Pooling of dye from a ruptured artery is seen in the arteriographic phase (A), while intense cortical opacification of the nephrogram (B) demonstrates the laceration found at surgery (SF 226-644).

sential. Application of non-crushing clamp to the renal artery as soon as possible in the operation permits safe debridement of clots without further bleeding, and accurate appraisal of the extent of injury as well as repair if it is indicated. Repair of trau-

matic lacerations of the renal cortex is by methods of suturing similar to those used for nephrolithotomy. Extraperitoneal drainage after operation is needed. If there is a

large perirenal hematoma, access to the renal artery for application of a non-crushing clamp is facilitated by an abdominal or thoraco-abdominal incision.

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Practice of Physical Therapy Under the Illinois Physical Therapy Registration Act

Under the original law enacted in 1951, registration of physical therapists was not compulsory; but only those therapists who were registered by the State of Illinois could hold themselves out to be registered or licensed, or use the letters R.P.T., or any other letters which implied registration or licensure.

Under the Illinois Physical Therapy Registration Act, as amended in 1965, registration of physical therapists is compulsory. No person who is not registered by the State of Illinois can hold himself out to be a physical therapist.

The law states that the Certificate of Registration may be refused, suspended or revoked if a physical therapist practices or undertakes to practice physical therapy "independently of the prescription, direction and supervision of a person licensed in Illinois to practice medicine in all of its branches or any system or method of treating human ailments without the use of drugs or medicines and without operative surgery or dentistry."*

During the month of April of every year, the Director of the Department of Registration and Education, State of Illinois, will publish a list of registered physical therapists authorized to practice in the state. Any interested person is entitled to apply to the director for a copy of the list which will be sent to him at cost. All registered physical therapists will receive the list each year.

The Illinois Chapter of the American Physical Therapy Association publishes a list of its members, copies of which are sent to most hospitals in the state, as well as to all members of the Illinois Chapter. Requests for copies of the listing can be sent to Jim M. Gray, R.P.T., 1211 S. Sixth St., Springfield 62703.

* Section 15, paragraph 9.

The Ileoptomists of Chicago

By RICHARD I. BREUER, M.D. / CHICAGO

The Ileoptomists, a mutual aid service organization devoted to the rehabilitation of the ileostomy patient, held its first panel presentation for physicians and nurses at Billings Hospital on Oct. 26, 1966. Dr. Joseph B. Kirsner, Professor of Medicine at the University of Chicago, who helped found the organization eight years ago with six ileostomy patients, introduced the panel to the audience. Dr. Kirsner emphasized how valuable Ileoptomists have been to him and his colleagues in helping to increase their knowledge of the care of the ileostomy patient and the ileostomy. He noted also the importance of this group to the medical profession through its cooperation with physicians in studies of normal small bowel function such as that carried out by Ingelfinger and Kramer on the excretion of solids,¹ and several projects currently in progress at the University of Chicago.

Mr. Maurice Ettelson, president of the Ileoptomists, outlined the services of the group. A most important function is visiting patients, pre- or post-operatively, at the request of the patient's physician. This serves as an aid to the physical, emotional, and social rehabilitation of the ileostomy patient.

The Ileoptomists try to match the patient with a visitor of similar age, sex, and marital status. Panel presentations to hospital groups are designed to improve liaison with the medical profession and to increase knowledge and improve instruction on ileostomy care. A detailed series of slides shows

how to apply the ileostomy appliance to the stoma, and the discussion emphasizes recent solutions to problems of appliance hygiene. Another objective is to teach the public that ileostomy patients are competent for employment and socially acceptable. In 1963 the local group completed a survey on the employment capabilities of Ileoptomists. This, in turn, has helped patients find jobs in many fields. Recently, a group life insurance program at standard rates has been offered to members of the United Ostomy Association, with which the local group is affiliated. The Ileoptomists also have encouraged the interests and efforts of manufacturers in developing more useful ileostomy appliances. The members have also agreed to further participation in ethical research designed to add to knowledge of intestinal physiology.

The Ileoptomists, Inc., an Illinois non-profit corporation with headquarters in Chicago, now has over 175 active members, a mailing list of 450, and an attendance at monthly meetings of about 50 plus interested members of the medical and nursing professions. Its success has contributed to the growth of the United Ostomy Association, a national organization which includes about 65 regional groups and over 6,000 members who have ileostomies, colostomies, or ureterostomies. The monthly publication of the Chicago group, "The Ileoptomist," has gained recognition by winning the Best Publication Award of the United Ostomy Association for three years in succession.

The Ileoptomists of Chicago have also played a leading role in aiding similar groups throughout the world by compiling literature pertinent to organization and function. Through its "Guide for Audio-visual Techniques," distributed through the national association, it has stimulated successful panels by other groups. This remarkable document contains suggested organizational material for panels, the result of marital, employment, and other surveys, and reprinted articles by leading physicians and surgeons on problems of ileostomy care and patient management. Included are writings by Dr. Harold Kaufman of Northwestern University and Dr. Harry Bacon of Temple University on surgical problems, by Dr. Paul Lazar of Northwestern and Dr. Rupert Turnbull of the Cleveland Clinic

(Continued on page 335)

Results of a Double-Blind Clinical Study of a New Anticholinergic Agent As an Axillary Antiperspirant

ALAN E. LASSER, M.D. / SKOKIE

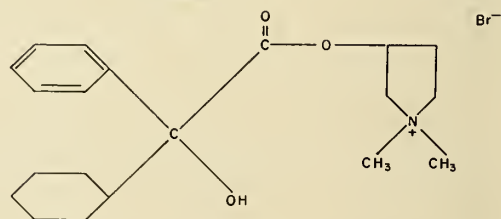
A total of 112 volunteers took part in a subjective double-blind study of a new topical anticholinergic agent, hexopyrronium bromide, as an axillary antiperspirant. Subjectively hexopyrronium bromide is as effective as aluminum chlorhydroxide and hexopyrronium bromide with neomycin. Side effects were minimal and were primarily attributable to the vehicle. The difficulties involved in attempting a critical subjective study are discussed.

Ever since the early 1950's there has been sporadic interest in the use of systemic and topical anticholinergic agents for the inhibition of sweating.¹ Systemic anticholinergic agents are not commonly used for this purpose because the dosage required produces other signs of toxicity, i.e., tachycardia, dryness of throat, abdominal pain, blurred vision, and agitation. Topical efficacy depends on the anticholinergic agent reaching the site of main cholinergic action which is receptor sites in the sweat gland itself. This has been referred to as the muscarinic effect of acetylcholine to distinguish it from the nicotinic effect of acetylcholine in the postganglionic parasympathetic nerve fiber (axon reflex sweating).² The effect of topical anticholinergics is thought to be due to a blockage of the muscarinic effect.

The ability of a topical agent to penetrate the skin and reach the sweat gland deep in the dermis depends on the physico-chemi-

cal properties of the topical agent, the state of the physiologic barrier layer, and the vehicle used. Of 11 anticholinergic agents studied by Shelly and Horvath via iontophoresis to eliminate the effect of the vehicle, scopolamine hydrobromide was the most effective in sweat inhibition followed by atropine methylnitrate and atropine sulfate. They found that a 1 percent aqueous solution of scopolamine hydrobromide produced partial anhidrosis in a few hours and an 18 percent solution produced total anhidrosis for eight days. However, the risk of systemic absorption, especially in areas of dermatitis where the barrier is easily breached, was always present and the risks of systemic toxicity including rapid death made the topical usage of this agent inadvisable. Nontoxic doses were found to be ineffective in sweat inhibition.³ MacMillan, Reeler, and Snyder⁴ have recently evaluated many scopolamine esters and reported no side effects, irritation, or sensitization, and a 40-60 percent inhibition of sweating with a 1 percent solution of scopolamine methylbromide. This percentage of inhibition is compatible with figures reported for present day commercial antiperspirants containing aluminum salts.⁵

Figure 1



AHR-483

(1-methyl-3-pyrrolidyl alpha-phenylcyclohexanecarboxylate methobromide)
Hexopyrronium bromide

From the Department of Dermatology, University of Cincinnati College of Medicine, Cincinnati General Hospital, Cincinnati, Ohio. Study materials furnished through the courtesy of A. H. Robins Co., Richmond, Va.

AHR-483 (hexopyrronium bromide), 1-methyl-3-pyrrolidyl alpha-phenylcyclohexaneglycolate methobromide (Fig. 1), is a synthetic anticholinergic agent closely related to glycopyrrolate (Robinul) which has been used extensively in the treatment of peptic ulcer.^{6, 7} Stoughton et al⁷ reported a 40-69 percent inhibition of axillary sweating in 18 young adults via the gravimetric method and using 0.5 percent AHR-483 in 0.4 percent hydroxyethylcellulose in distilled water applied in a roll-on container. Studies of sweat inhibition on the forearm with the starch-iodine technique were most effective using a 0.5 percent aqueous solution. No irritation, sensitization or systemic toxicity were noted even after 90 percent body inunction using 75 mg. of AHR-483. The following report is a summary of our data on the effectiveness and patient acceptability of AHR-483 in a double-blind study. This is, then, a subjective study in which the subjects' personal prejudices are the sole criteria. No objective studies were done.

Materials and Methods

All of the 112 volunteers were members of the medical family, i.e., ward attendants, aides, nurses, secretaries, medical students, and physicians because it was felt that they would be more conscientious observers and more objective in their subjective response. The material was supplied by the A. H. Robins Co. in coded plastic roll-on containers. The code was not available to the investigators or the volunteers until after the entire study was completed. The bottle and the cap were labeled "Left" and "Right" to avoid mixup. Different preparations were applied to each axilla. The preparations investigated were:

- (1) 0.5 percent hexopyrronium bromide (AHR-483)
- (2) 0.5 percent hexopyrronium bromide and 0.175 percent neomycin sulfate
- (3) 18.0 percent aluminum chlorohydrate
- (4) Placebo (vehicle only) 0.4 percent hydroxyethylcellulose in distilled water.

The ages of our volunteers ranged from 14 to 53 with the majority being in the third and fourth decade. There were 88 females and 24 males. The investigated ma-

terial was rolled onto the axillary vault area once or twice daily depending on personal preference. No pregnant women were included in this study. Length of time on the study material ranged from five to 126 days. There was no variation in the number of subjects on the study at any particular season of the year.

Results

The volunteers were asked to compare each of the two agents used to the effect they would expect from a placebo (Table 1), to the effect as compared to the commercially available antiperspirant-deodorant they had used prior to the study (Table 2), and to which of the two agents they would prefer if a preference was present (Table 3). Side effects were few and are listed in Table 4.

Comment

The most obvious outcome of the study is the lack of a clear-cut preference for any single antiperspirant present in this study from the users' point of view. Our study further points out the tremendous individual variation in response and interpretation of that response.

An ideal antiperspirant should fulfill four requirements: effective inhibition of sweating, decrease odor, do no harm, and be cosmetically acceptable. Most commercially available antiperspirants are aluminum salts and have been reported to inhibit sweating by approximately 50 percent.⁵ The mechanism of action of these salts is thought to be resorption of sweat from the eccrine duct before it reaches the surface. Histologic sections have shown periductal inflammation after using aluminum salts.⁸ Aluminum salts have been shown to have antibacterial properties and decrease odor.⁹ However, most commercially available agents rely on hexachlorophene or a similar bacteriostatic substance to combat odor. Neomycin is an excellent agent in this regard but it has more sensitizing potential than does hexachlorophene. Side effects from available antiperspirants have been few if one considers only allergic sensitization, and these are usually due to the perfume. Systemic toxicity from absorption of a present day commercial cosmetic antiperspirant has

not been reported to my knowledge. Irritation reactions, however, are relatively common and are usually secondary to shaving, too frequent washing and drying or secondary to some primary cutaneous disease process of the axilla. The cosmetic industry excels in making their products cosmetically acceptable. Antiperspirants are available with various perfumes and in any size, shape, or form imaginable. In a subjective study such as this the lack of cosmetic embellishments such as perfume may have significantly influenced the users' interpretation. Likewise, the use of a roll-on method of application may have alienated the proponents of the cream, stick, spray-on, or pad method.

TABLE 1
RESULTS OF TEST AGENTS COMPARED TO A PLACEBO

	BETTER (Column A)	SAME (Column B)	WORSE (Column C)
H*			
(55 subjects)	29 (53%)	16 (29%)	10 (18%)
N**			
(54 subjects)	34 (63%)	7 (13%)	13 (24%)
P***			
(57 subjects)	23 (40%)	14 (25%)	20 (35%)
A****			
(58 subjects)	33 (57%)	13 (22%)	12 (21%)

* Hexopyrronium bromide 0.5%
** Hexopyrronium bromide 0.5% plus Neomycin sulfate 0.175%
*** 0.4% Hydroxyethylcellulose in distilled water
**** Aluminum chlorhydroxide 18.0%

The comparison of the agent used to the subjects' preconceived conception of a placebo (Table 1) seems merely an exercise in conjecture. It is interesting, however, that only 14 (25 percent) subjects using the placebo were able to correctly judge it as such. On the other hand, 23 (40 percent) of the subjects were placebo reactors which is slightly higher than the 33-37 percent¹⁰ expected. When the percentage of subjects who chose placebo as "better" is subtracted from the percentage who chose one of the active test materials, as "better" (Column A), the remaining percentages (which are presumably due to drug effect) approximate the percentages under "worse" (Column C). A similar study at our medical center using only medical students and nurses to insure a highly critical sampling and using a topical scopolamine ester antiperspirant

supplied by a different company produced similar results.¹¹

Table 2 is less speculative in that it compares the subject's response to the test antiperspirant with his memory of the effect obtained from the antiperspirant used prior to this study. This comparison is also biased by the fact that test agents were completely without cosmetic embellishment. Our results here even though heavily weighted on the negative side show no significant differences between the three active agents tested. Hexopyrronium bromide, therefore, appears to be at least as good as aluminum chlorhydroxide and has already been shown objectively by the studies of Stoughton et al⁷ to inhibit sweating by 40-60 percent.

TABLE 2
RESULTS OF TEST AGENTS COMPARED TO COMMERCIALY AVAILABLE ANTIPERSPIRANTS

	BETTER (Column A)	SAME (Column B)	WORSE (Column C)
H*			
(55 subjects)	13 (24%)	22 (40%)	20 (36%)
N**			
(54 subjects)	11 (20%)	26 (48%)	17 (32%)
P***			
(57 subjects)	8 (14%)	20 (35%)	29 (51%)
A****			
(58 subjects)	11 (19%)	26 (45%)	21 (36%)

* Hexopyrronium bromide 0.5%
** Hexopyrronium bromide 0.5% plus Neomycin sulfate 0.175%
*** 0.4% Hydroxyethylcellulose in distilled water
**** Aluminum chlorhydroxide 18.0%

In an additional three subjects with a history of severe axillary hyperhidrosis, 0.5 percent hexopyrronium bromide in 90 percent dimethyl sulfoxide (DMSO) was applied to one axilla and 90 percent DMSO was applied to the other axilla for a period of 14 days. Two of the three subjects showed decreased sweating in both axillae, but felt it was a bit more marked on the side that contained the hexopyrronium bromide. The other subject felt there was little difference between the study materials and his present antiperspirant. No evidence of local toxicity or irritation was noted.

Sixty of the 112 subjects had no preference (Table 3) between the two agents used and in 32 cases (over 50 percent) one of the test agents was a placebo. This is inconsistent with the results of Table 2 and again

points out the tremendous importance of cosmetic embellishment and advertising in the formation of personal preferences.

Side effects (Table 4) were minimal. The main side effects attributable to anticholinergics were negligible; one subject using both H and N complained of blurred vision for two days which disappeared spontaneously and two subjects (one using H & P and the other N & P) noted dryness in the mouth which stopped spontaneously after seven days. Both of these effects occurred within the first two weeks of usage. Although side effects possibly related to topical anticholinergic agents were negligible and more detailed studies for systemic toxicity, irritation and sensitization were also negative,^{4,7} such potentially potent pharmacologic agents should be used under direct physician supervision and not be available for over-the-counter sale. This would be especially true if DMSO or a similar agent is again available as a vehicle for topical agents because the increased penetration increases the possibility of systemic absorption and toxicity.¹²

Seven subjects complained of stickiness. This occurred with all the agents used and is probably due to a personal aversion to roll-ons or to the vehicle. Four subjects complained of irritation and two complained of an eruption which lasted less than seven days. These again occurred with all the agents tested and usually occurred after shaving. All skin irritation subsided when use of the test drugs was discontinued. One of the two subjects again used the agent after her eruption cleared without recurrence of skin irritation.

TABLE 3 RESULTS OF PREFERENCES					
Preference			No Preference		
H greater than N	4		H & N	11	
H greater than P	7		H & P	9	
H greater than A	4		H & A	8	
			N & P	13	
N greater than H	2		N & A	9	
N greater than P	4		P & A	10	
N greater than A	4				
P greater than H	2				
P greater than N	1				
P greater than A	5				
A greater than H	8				
A greater than N	6				
A greater than P	5				

TABLE 4 SIDE EFFECTS	
Dry Mouth	2
Blurred Vision	1
Urinary Hesitance	0
Constipation	0
Rash	2
Irritation	4
Stickiness	7
Odor	2
Stains Cotton	1

Conclusions

Our data shows the difficulty inherent in a critical subjective evaluation of topical antiperspirants. Further studies are needed with and without cosmetic embellishment and in all possible forms and choice of vehicles to further delineate the effectiveness of hexopyrronium as an antiperspirant. Our initial studies indicate that there is a place for hexopyrronium bromide in our present meager armamentarium but that its use should be limited to prescription by the practicing physician and not be available for over-the-counter sale.

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The Municipal Tuberculosis Sanitarium Population Changes

By M. R. LICHTENSTEIN, M.D. AND ARTHUR SORENSEN / CHICAGO

In recent years many physicians picture the tuberculosis sanitarium as a sanctuary where the patient is isolated for a few weeks or months to become negative and then return to work. Over the past 10 years marked changes have occurred in the type of patients entering the Municipal Tuberculosis Sanitarium so that sanitarium work is quite different from previous experience. The changes in patient population are seen in the studies made in 1952, 1957,¹ and 1966, of a cross-section of patients hospitalized at the time and are significant for the future use of tuberculosis beds in large cities.

The daily average number of patients in the Municipal Tuberculosis Sanitarium in 1957 was 1,324; in 1966 it was 875. Over the period from 1955 to 1965 tuberculosis deaths in Chicago decreased by 64 percent and new cases by 50 percent.

Age: There has been a pronounced increase in the age of patients at MTS. Male patients over 60 years old made up 11 percent of the males in 1952, 23 percent in 1957 and 30 percent in 1965. Males under 50 years decreased from 71 percent in 1952 to 44 percent in 1966. In 1966 there were 99 males over 65 years of age, 34 of whom were over 75 years old. Females less than 30 years old made up 82 percent of the female patients in 1952, 69 percent in 1957 and 22 percent in 1966. At present there are 39 females over 65 years old, 15 of whom are over 75 years old.

Race and Sex: A progressive decrease in white patients and increase in Negro patients has occurred.

	white male	Negro male	white female	Negro female
1952	60%	34%	43%	49%
1957	64%	29%	39%	52%
1966	53%	40%	35%	57%

Males predominate in the Sanitarium population 72 percent to 28 percent females at present. Ten years ago the proportion of females was somewhat higher forming 33 percent of all adult patients.

On Nov. 20, 1966, the Sanitarium population of 847 consisted of 403 white patients (including 27 Mexicans and 17 Puerto Ricans), 417 Negro patients, 10 Orientals, 14 American Indians and three others.

Marital Status: Of the male population 19 percent were married and living with a spouse before admission; 33 percent were unmarried and 50 percent lived alone. Of the females 27 percent lived with the husband; 21 percent were single, the remainder widowed, separated or divorced; 34 percent had no children, 32 percent had one or two children and 10 percent had six or more children.

Education: About 60 percent of the males and 40 percent of the females had eight years or less of schooling. 15 percent of the males and 17 percent of the females had graduated from high school. The percentages mentioned did not change much over the past 10 years. The percentage who failed to complete five years of schooling (functional illiterates) however, today constitutes a majority of the patients and is considerably greater than 10 years ago. Many of these have come from the deep south or Puerto Rico.

Skills: The decrease in the percentage of skilled male workers is notable: 32 percent were skilled in 1952, 21 percent in 1957 and

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15 percent in 1966. About 65 percent of all males and females are unskilled or semi-skilled.

Occupational Record: 35 percent of males had worked up to one month before admission, 12 percent from one to six months before admission; 48 percent had not worked for six months or more prior to admission.

Alcoholism and Drugs: Among males 101 or 21 percent were diagnosed as chronic alcoholics, largely skidrow inhabitants, and 155 or 32 percent as heavy users, a total of 53 percent excessive drinkers; 7 percent of females were similarly diagnosed. There has apparently been little change in the percentage of alcoholics over the past 10 years. Of the adult population, 3 percent had a history of drug addiction, 8 percent had a history of a mental problem and 3 percent were known to have a penal record.

Other Disabilities: Tuberculosis is frequent among diabetics, the latter almost always making up about 5 percent of the Sanitarium population. At present there are 46 diabetics in the hospital.

Fifty patients with emphysema (and tuberculosis) constitute one of the commonest associated diseases. Forty-six patients have obvious evidence of mental illness. Forty patients have serious cardiac disease, many in the last stages of failure. Other illnesses are 19 with hernias, 13 carcinomas, 13 with hypertension and 11 with venereal disease. A few cases each of ulcer, asthma, epilepsy, arthritis, etc. are always present.

As a result of the compulsory x-rays of admissions to homes for the aged, the Sanitarium has a number of elderly patients, disabled primarily by cardiac disease, strokes or cancer. Their tuberculosis is frequently minimal but they require a great deal of medical and nursing care.

Distribution of tuberculosis in the city: in 1965 78 percent of the new tuberculosis cases in Chicago were found in 25 community areas composing about one-third of the city but containing 54 percent of the population. This area is the oldest, most congested, lowest economic part of the city containing most of the non-white population, and the indigent or near indigent whites. The tuberculosis death rate (1965) in the above 25 community areas was eight per 100,000 as contrasted with a rate of two

per 100,000 in the remaining 51 community areas of the city. (The U. S. rate was about four per 100,000.)

Tuberculosis Beds for Chicago Residents: There are about 1,200 beds in use at present (Municipal Tuberculosis Sanitarium 875; Chicago State Tuberculosis Sanitarium 150; Veterans Administration, Hines 190). The number has decreased by 600 beds over the past five years.

Comment

Some years ago the sanitarium population was largely youthful, white, and had relatively few with serious associated diseases. There has been a progressive increase in age, in the percentage of non-whites and in the number who are primarily incapacitated by age and diseases other than tuberculosis. This trend can be expected to continue, creating increased need for medical and nursing attention for the bed-fast patients with poor prognosis.

Another group, the alcoholics, usually functionally illiterate, constitute a difficult or impossible problem in rehabilitation. They tend to leave the sanitarium against medical advice before much educational improvement is possible. They relapse and are readmitted, frequently resistant to chemotherapy. Retreatment with secondary drugs requires additional hospital time and much laboratory work because of the toxicity of the drugs. A large percentage of treatment failure occurs in this group.

Along with the difficult and unfavorable groups mentioned above, a large proportion of cooperative patients who attain an excellent result flow through the sanitarium in an average of six months. These continue in out-patient chemotherapy and return to their former occupations in due course.

Over the past 10 years the sanitarium pediatric ward has reduced beds from 90 to 30. The decrease in tuberculosis among children, adolescents and young adults has been an outstanding and encouraging development.

Summary

The Municipal Tuberculosis Sanitarium population is increasingly composed of elderly patients primarily incapacitated by associated diseases and by functionally illiterate

(Continued on page 349)

Preoperative and Postoperative Use of Pentazocine, a New Non-Narcotic Analgesic

By HERBERT R. GAINES, M.D. / CHICAGO

In October of 1964 this department set about to evaluate the clinical efficacy of pentazocine* in the postoperative recovery room environment. Our interest had been aroused by the prior work of Keats¹ and Sadove² who had done preliminary clinical pharmacology studies. Since physicians have long sought a synthetic analgesic that could duplicate the action of morphine without the addiction liability and with minimal side effects, it is understandable that our interest in pentazocine was high.

Pentazocine is a unique member of the group of benzmorphane compounds possessing narcotic-antagonistic properties in addition to being strong analgesics. It differs from nalorphine and levallorphine in that it is a weak antagonist compared to their more specific antagonistic action against morphine and meperidine; pentazocine in analgesic doses does not produce psychotomimetic effects as do nalorphine and levallorphine. Pharmacologically, pentazocine in doses of 20-40 mg. rivals the activity spectrum of 10 mg. morphine sulfate or 50-75 mg. meperidine HCL.^{1, 3}

Addiction liability as studied in rhesus monkeys by Deneau and Seevers,⁴ showed that pentazocine failed to produce any specific suppression of the total spectrum of morphine-abstinence signs. Studies by Fraser and Rosenberg⁵ at the Addiction Research Center in Lexington, Kentucky concluded that in man, pentazocine had no significant degree of morphine-like addiction.

Since the number of injections given to a

patient post-op is unlikely to produce addiction, there was little concern for this possibility within the scope of this study.

Materials & Method

The patients involved were selected as they were scheduled for elective or emergency surgery. All 585 cases were given pentazocine by intramuscular injection with the exception of a few who received the drug intravenously (30 mg.). Patients were given doses of pentazocine as their needs demanded with the majority requiring only one injection of 30 mg. 30 to 45 minutes post surgically. Of the total number of patients treated, 507 were postoperatives and 78 patients received pentazocine as premedication combined with hydroxyzine (Vistaril®) and atropine sulfate in the same syringe. Included in the series were 51 post-operative pediatric patients. (Tables 1 & 5)

Dosages of pentazocine employed ranged from a low of 15 mg. to a high of 60 mg., with 80 percent (407) of the patients receiving 30 mg., while 19 percent (98) received 60 mg. (Table 2) Onset of analgesia was usually within fifteen minutes and more frequently than not outlasted the patient's stay in the recovery room. Relief of pain was graded as Excellent, Good, Fair or Poor on the basis of physician and nursing personnel evaluations correlated with the patient's subjective responses.

An Excellent rating was assigned to the patient who had complete relief of pain whose vital signs remained stable, and who went to sleep within 10-15 minutes post-injection and remained asleep unless aroused.

A Good rating was given to those patients who had relief of pain and only complained sporadically of mild discomfort.

A Fair rating was given when patients

* Pentazocine will be produced as Talwin® by Winthrop Laboratories, New York, N. Y.

continued to complain of pain or discomfort and in whom the analgesic effects were of short duration.

A Poor rating indicated little or no pain relief with continuation of moaning and hyperkinetic movement. (Table 3)

Comment

Early in this study it was apparent that pentazocine, in the 30 mg. dose, was providing good to excellent analgesia in a high percentage of cases. For example, of the first 90 cases treated, 72 percent were rated Good to Excellent and 18 percent were rated in the Fair category. It is also interesting to note that it was within this same group

that nine of the 15 cases rated Poor were encountered. Although inadequate dosage cannot account for all of these Poor rated cases (some received 60 mg. doses) later experience with many more patients suggests that this was most probably the reason for failure.

Table 1

Sex Distribution and Totals	
Females	354
Males	180
Pediatric Females	18
Pediatric Males	33
TOTALS	585

Table 2

Dosages Used	—	All patients*	Dosages Used	—	Pediatric
30 mg.		407	30 mg.		44
45 mg.		3	45 mg.		1
60 mg.		98	60 mg.		2
15 mg.		4	15 mg.		3
25 mg.		1	25 mg.		1

*Note: Includes 3 patients who received more than one dose

Table 3

Pain Relief	—	All Cases**	Pain Relief	—	Pediatric Cases
Excellent		218	Excellent		22
Good		216	Good		21
Fair		61	Fair		8
Poor		15	Poor		0
TOTALS		510*			51

* Includes 3 patients with more than one rating due to multiple doses.

** Does not include pre-op cases.

Table 4

Pre-operative Medication:		Pentazocine 15 mg.:	
Pentazocine 30 mg.:		Hydroxyzine 25 mg.	
Hydroxyzine 50 mg.			
Excellent	30	Excellent	1
Good	22	Good	18
Fair	2	Fair	4
Poor	0	Poor	1
Totals	54		24

Table 5

AGE DISTRIBUTION

			Pediatric Patients:		
Adults	Male	Female	Male	Female	
Oldest	85	83	Oldest	15	15
Youngest	16	16	Youngest	1	4
Avg. Age	46.1	42.8	Avg. Age	8.1	10.7
Combined			Combined		
Avg. Age	43.9		Avg. Age	9.1	

Seventy-eight patients were injected preoperatively with a combination of pentazocine, hydroxyzine and atropine to test the efficacy of pentazocine as a premedicant, as well as to determine, to some degree, whether or not the presence of a phenothiazine had any potentiating effect upon pentazocine. Fifty-four patients were given 30 mg. pentazocine and 50 mg. hydroxyzine; 24 patients received 15 mg. pentazocine and 25 mg. hydroxyzine. All 78 were given atropine sulfate 0.4 mg. The three drugs were administered intramuscularly from a single syringe and no patient complained of any untoward stinging or inflammation at the site of injection. The 30:50 mg. pentazocine:hydroxyzine group showed 30 cases rated Excellent, 22 rated Good, 2 Fair and no patients rated Poor; the 15:25 mg. group revealed only 1 Excellent, 18 rated Good, 4 Fair and 1 Poor. (Table 4) Although the number of patients is small, there is no doubt that the 30:50 mg. dose schedule yields a higher ratio of Excellent to Good responses than the 15:25 mg. dose. The overall picture gives a 95 percent satisfactory premedication rating to the 30:50 mg. dose versus a 79 percent success with the 15:25 mg. Based on the evaluation of previously treated preoperative cases using other narcotic drugs with hydroxyzine, it would appear that those patients given the aforementioned combination were adequately prepared for their surgical procedures and entered the operative theatre relaxed, relatively calm, and cooperative. The quality of the premedication was superior with the higher dose regimen. The series was too small to properly evaluate whether or not the addition of hydroxyzine would allow a lowering of pentazocine dosage and still achieve satisfactory analgesia and sedation.

At no time during the study were incompatibilities encountered when other medications were used in conjunction with pentazocine, and this includes those patients treated preoperatively as well as postoperatively with a variety of drugs.

A review of the different types of surgical procedures performed showed the usual varied distribution for a large general hospital. In addition, there were a number of special procedures such as fractures, radium insertions, bronchoscopies and a number of radiotherapies.

A singularly significant attribute of pentazocine, other than its apparent analgesic activity, is the quality of sedation and sleep production. All patients who were rated Good to Excellent for analgesia were well sedated and slept, either continuously or at intervals; yet, when these patients were questioned, they were easily aroused, responded, and resumed their sleeping. Nursing personnel were quite impressed with the ability of the drug to calm and tranquilize a screaming, moaning and restless patient, especially a child. This observation was made time and time again. In this series of patients 234 were reported as having been sleeping within 15 minutes of receiving pentazocine or sleeping at intervals and easily aroused.

Observations of the preoperative as well as the postoperatively treated patients revealed no significant changes in blood pressure requiring remedial measures. Blood pressures were recorded by the author prior to surgery and were used as the base for comparison during and immediately postoperatively. Where a rise or fall did occur it was never more than 10 percent and could not be related to the dose administered. No patient in this series manifested any untoward central nervous system reactions discernable by any observer during surgery, in the cases of those preoperatively injected, or post-surgery in the recovery room. Observations and measurements of respiratory rate and pulse rate recorded by nursing personnel in the recovery room showed these parameters to be without significant alteration in every case. Side effects, other than sedation and sleepiness, were few in number. Only one child vomited one hour after receiving pentazocine. No patient complained of pain, stinging or inflammation at the site of injection.

Summary

Pentazocine was administered to 585 patients primarily as a postoperative analgesic but also to a number of patients as a premedicant combined with other agents. Results show it to have a high level of analgesic activity without untoward side effects in these patients. Patients underwent a variety of surgical and special procedures and their pain was well controlled with a single intramuscular injection of pentazocine in the majority of cases.

In patients given only local anesthesia
(Continued on page 339)

Placenta Localization Using Radioiodinated—I¹³¹ Human Serum Albumin

By ERNEST BRUCH, PH.D., M.D., AND JOHN E. TILLIS, M.D.
WITH THE TECHNICAL ASSISTANCE OF
ELIZABETH M. SCOTT, S.N.M.T.

The use of radioisotopes for placenta localization has been suggested to be of value in cases of: (1) 3rd trimester vaginal bleeding; (2) Abnormal presentation or high presenting part, and (3) Prior to amniocentesis.¹ For over two years we have utilized placenta localization using radioactive I-131 tagged human serum albumin, hereafter referred to as I¹³¹ HSA, in cases suspected of being placenta previa.

Successful management of placenta previa involves early diagnosis and proper timing of delivery. The conservative or expectant treatment of possible cases of placenta previa began in 1945. This is based on the observation that the initial hemorrhage and often the episodes of subsequent bleeding in placenta previa are frequently not severe; particularly if the cervix is not examined manually. It is then often possible to observe the pregnancy until the fetus is mature enough to survive, even if this involves prolonged hospitalization.

Eliminates Prolonged Hospitalization

Since probably only 10 percent of third trimester bleeding is due to placenta previa, it is of utmost value to have a method of localizing the placenta as accurately as possible. This would eliminate the necessity of applying "conservative treatment" with prolonged hospitalization to all cases of bleeding. It can also relieve apprehension and emotional stress to the patient² (and

to the attending physician) when placenta previa can be satisfactorily ruled out.

Accurate localization is particularly needed before the 36th week of gestation. Before that time, the usual soft tissue X-ray examinations do not have as high a degree of accuracy as desired. In addition, before this time, intracervical digital examination may not be feasible or advisable. The cervix may not admit the finger. A lesser degree of placenta previa may be beyond the reach of the finger. If the patient has stopped bleeding, vaginal examination may precipitate massive hemorrhage, necessitating immediate surgical treatment.³

Browne and Veall⁴ first suggested isotopic placenta localization in 1950, using radioactive sodium (Na²⁴). Weinberg et al.³ reported in 1957 the more satisfactory use of I¹³¹ HSA. Several authors (1-3;5-12) have reported on I¹³¹HSA as a satisfactory way for screening of placenta previa because of its safety, simplicity, and degree of accuracy.

METHODS:

A supply of Radioiodinated (I-131) Human Serum Albumin Solution, (RISA-Abbott), is permanently available in the isotope laboratory on standing order. Sources, 9 microcuries to 10 microcuries in strength, diluted to a total volume of 10 cc. with sterile Saline, are calibrated for the day of the test, usually being prepared one day ahead of administration. The radioactive titer of the solutions was worked out by experience to fit the counting efficiency of the equipment. It varies from laboratory to laboratory, but is usually between 5 and 10 microcuries. The work at our laboratory was performed with an older

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type of scintillation probe (Nuclear Research and Development Inc., St. Louis, 1953), which has a 1 x 1 inch Sodium Iodide crystal and an RCA Photo Multiplier Tube (6342-A). This scintillation probe is connected by means of a 60-inch long cable with a preamplifier tube, which in turn is connected with an electronic clinical decadic scaler (Model No. 1290 of the Picker X-Ray Corporation); operating high voltage was 1350. In this arrangement, when the front end of the shielded scintillation probe was put in direct contact with the patient's skin without additional collimation, count rates between 1,000 and 3,500 per minute were obtained which were sufficient for statistical purposes. The work was exclusively performed in the isotope laboratory, not in the patient's room. Suitable for the study were patients in whom vaginal bleeding had stopped or had become minimal.

Protection of Thyroid Gland

In order to protect the thyroid gland of the mother and of the fetus from accumulation of such small amounts (0 to 5 percent) of inorganic Iodide-131 as are split off from the Iodine-131 tagged Human Serum Albumin, 30 drops of Lugol's solution or of saturated Potassium Iodide solution are given to the mother in two or three divided doses on the day before the study. If this is not feasible, 2 cc. of sterile 10 percent non-radioactive Sodium Iodide solution can be given intravenously one hour before the test. As an approximate basis for the calculation of the theoretical blood volume, the present or most recent weight and height of the pregnant woman are ascertained as accurately as possible.

The uterine area, as determined by palpation, is outlined on the patient's abdomen with a skin pencil, the lower borderline being formed by the upper margin of the symphysis pubis. This line topographically is at the same level as the internal os of the cervix. Horizontally the uterine area is subdivided into three segments at an upper, intermediate and lower level, by dividing the distance between the top of the fundus and the top of the symphysis pubis into thirds and drawing two horizontal lines at these levels. Likewise, two vertical lines divide the uterine area into three vertical segments by dividing the two previously mentioned horizontal lines and the line at

the symphysis into thirds and drawing two vertical lines through these division points. This results in a total of nine uterine segments which have been sufficient for our determinations.

Waiting Time Utilized

Rather early in our work we observed from repeated measurements that the specific area or areas of highest radioactivity counts from the placental blood pool were not always established 15 minutes after the intravenous injection of the $I^{131}HSA$. We also noted from the literature that the area or areas of peak radioactivity can be differentiated or identified up to 16 hours after injection.³ For these reasons we elected to wait at least 45 minutes and utilize the waiting time for blood and plasma volume determinations by drawing a blood specimen of 20 to 22 cc., about 15 minutes after the injection, using a 20 gauge needle and two 10 cc. syringes. The specimens were emptied into two separate collection bottles, each of which contained the dried residue from 1.1 cc. of Wintrobe (potassium oxalate-ammonium oxalate) anticoagulant solution. The anticoagulated blood from one of the bottles was centrifuged for 10 minutes at 4,000 R.P.M.; the supernatant plasma was pipetted off and a 4 cc. aliquot was counted for two minutes in the scintillation well counter for the plasma volume determination.

While the above-mentioned centrifugation is in progress, duplicate specimens of 4 cc. each from the other anticoagulated blood bottle are used for determination of the uncorrected total blood volume. Furthermore, duplicate blood specimens for a standard Wintrobe hematocrit determination are taken from the same collection bottle and centrifuged for 30 minutes at 3,000 R.P.M. A correction factor of 0.92 is used to convert the Wintrobe hematocrit into the body hematocrit. While the blood and plasma specimens are counted immediately in the well counter after they have been obtained, the reading of the duplicate Wintrobe hematocrit can be done while the external placenta localization is in progress, and the detailed calculations of the blood and plasma volume and associated values can be finished after the completion of the placentalgram.

This incidental volumetric work has supplied us with interesting and valuable in-

formation on the patient's gross blood volume, the corrected blood volume, the plasma volume, the red cell mass, the Wintrobe hematocrit and the "radioisotopic hematocrit," all measured hematocrit percentages reflecting the composition of the peripheral venous blood.

The red cell mass was calculated by subtracting the plasma volume from the gross blood volume. The radioisotopic hematocrit was calculated by multiplication of the red cell mass (volume) times 100 and subsequent division by the gross blood volume. In most cases, the Wintrobe hematocrit and the radioisotopic hematocrit agreed within 1 to 2 volume percent.

The various results were compared with the theoretical values for a healthy, non-pregnant female of the same height and weight, and they were also compared with the values which are shown by healthy pregnant women of approximately the same stage of pregnancy with its considerable physiologic changes.

In view of the fact that the patients had had vaginal bleeding of varying extent before they were referred for placenta localization, we felt that these blood and plasma volume determinations gave us valuable additional clinical information, aside from the routine complete blood counts supplied by the pathology laboratory. While we are aware of certain theoretical objections and difficulties when trying to determine accurately a maternal blood volume in pregnancy and to arrive at normal standards of comparison, we were impressed by the fact that the I^{131} HSA for practical purposes does not cross the placental barrier and therefore its dilution in the circulating blood practically reflects the maternal blood volume only. The results of our determinations have supplied us with pertinent and valuable information on the hematologic status of the patients under investigation and they have correlated quite well with the findings of other recent investigations in this field.¹⁴

EXAMPLE

Case 4, Table I. Colored female, age 32, 30 weeks pregnant. Height 68 inches, weight 187 lbs. or 85.1 kg. Body surface area 1.98 sq. meter (Dubois and Dubois).

Peripheral (Wintrobe) hematocrit 38.0 vol.%. Corrected to body hematocrit 35.0 vol.%. Radioisotopic hematocrit: 39.1. vol.%.

Total blood volume (uncorrected) 7,896 cc. or 92.7 cc. per kg. (normal 61.8 to 75.3). Plasma volume (not needing correction) 4,806 cc. or 56.4 cc. per kg. (normal 39.3 to 43.0). Red cell mass (by difference) 3,090 cc. or 36.2 cc. per kg. (normal 30.8 to 31.3).

Blood volume corrected (via plasma volume and body hematocrit) 7,388 cc. or 86.7 cc. per kg.

Theoretical blood volume for a non-pregnant patient of same body surface area: 5,280 cc. or 62.1 cc. per kg.

Interpretation of results: "Considerable expansion of the total blood volume (uncorrected and corrected) with special expansion of the plasma volume, quite in agreement with the physiological changes in the early eighth month of pregnancy. It is in favor of the patient that the red cell mass also has risen somewhat above the normal level, as it should be. The peripheral hematocrit findings (Wintrobe and Radioisotopic) were rather favorable and indicated only a mild so-called secondary anemia of pregnancy. The recent uterine bleeding apparently had been fully compensated."

Usually, 60 to 70 minutes after injection of the I^{131} HSA, the radioactivity from the nine uterine segments was counted for one minute each and the tissue background was counted at the mid-thigh. If the segmental count was to be expressed in percentage figures, then the 100 percent reference point of comparison was the count obtained over the xiphoid process. All segmental counts were repeated in order to verify satisfactory stability of the distribution pattern of the radioisotope. After deduction of the tissue background the two net counts from each segmental area were averaged.

Net Counts Evaluated

For evaluation and comparison of the segmental net counts, three procedures were available:

(A) Direct reading and selection of the significant highest counts by estimation; (B) Setting the net count of the xiphoid site as 100 percent and expressing the individual counts of the nine uterine segments as comparative percentages of the xiphoid count. Significant areas showed percentages above 73 percent; (C) Working without a reference point outside the uterine area and evaluating only the net counts of the nine

uterine segments in the following way: The highest and the lowest segmental net counts were added and the sum was divided by two. Any segment which had yielded a net count higher than this arithmetic average was regarded as significant.

All three methods yielded three or four significant areas which were reported in order of magnitude. After utilizing all three procedures we finally preferred method (C) as the most satisfactory and practical one for our purposes. The final average net counts were entered on a diagram showing the nine uterine segments, and the three or four significant segments were marked according to their degree of radioactivity as the probable location of the placenta. A preliminary drawing was placed into the progress notes of the clinical record or it was transmitted to the attending obstetrician over the telephone. The drawing appeared again in the final isotope laboratory report, which also included the results of the blood and plasma volume determinations.

We realized that in view of the numerous positions which a placenta can occupy in the pregnant uterus, it is quite difficult to make a fully satisfactory diagnosis of location from radioactivity counts obtained from the anterior and semi-lateral abdominal wall. Posterior position or deflection of part of the placenta sometimes could be assumed from the appearance of a low significant count between two high significant counts or by obtaining a high significant count laterally (or somewhat posterior) to the outline of the uterine area on the patient's abdomen. In our written report we evaluated the findings in regard to the most likely position of the main mass of the placenta and its possible extensions. Typical diagrams and reports are in the case report section of this article.

RESULTS

Over the past two years, 22 placenta localizations were performed. The cases are summarized in Table 1. All localizations were done for unexplained vaginal bleeding. Most were done between 28 and 35 weeks of gestation. Fifteen patients were hospitalized, and seven localizations were done on out-patients.

The terms used for placenta localization in Table 1 and in the case reports are:

1. **HIGH**—placenta completely in the upper segments of the uterus, (upper two-thirds of diagram).

2. **LOW REACHING**—(low-lying; marginal placenta previa or sometimes complete placenta previa)—some part of the placenta is in the lower segment of the uterus, (lower one-third of diagram).

3. **TOTAL**—internal os covered by the placenta (lower one-third of diagram filled with placenta).

Of the nine cases with placement designated as **HIGH**, none were found to be previas. Seven had no further difficulty and were delivered at term. One had no further bleeding, but delivered two weeks later pre-maturely at 34 weeks gestation. One patient continued with mild bleeding and remained hospitalized for three more weeks; massive hemorrhage at 31 weeks necessitated a Cesarean section for complete abruptio placentae.

Of the 11 cases with placement designated as **LOW REACHING**, apparently all were correctly diagnosed. Six delivered vaginally: one bled during labor from a palpable low lying placenta; of the other five, one record mentioned a low lying placenta and the positions of the other four placentas were not noted at the time of delivery—five of these 11 had Cesarean sections; all five had recurrent bleeding. One was a low-lying placenta, two were marginal placenta previas, and two were complete previas.

The two cases with placement designated as **TOTAL** had Cesarean sections; both were complete placenta previas.

Our accuracy is and should be 100 percent in the **HIGH** and **TOTAL** groups. We can ascribe 100 percent accuracy to the **LOW REACHING** group, if we appreciate the limitation of our diagnostic ability. The **LOW REACHING** designation will include cases ranging from small edges of the placenta in the lower segment to a marginal or complete previa. Better analysis is presently not technically possible from segmental activity counts. Basically, however, the purpose of this designation is to alert the physician to the presence of a possible cause of recurrent bleeding. The management of these cases, then, will depend more upon their clinical course than upon a more quantitative localization of the placenta.

TABLE 1
SUMMARY OF PLACENTA LOCALIZATIONS
at St. Anthony Hospital

		GESTATIONAL AGE & LOCALIZATION				FOLLOWUP	
CASE	HOSP.#	AGE	GR.	PARA			
1	3-1505	24	4	3	28 wks.	LOW	Home. Bled at 31 wks. Del. vaginally at 33 wks. with low-lying placenta.
2	3-2597	21	3	2	31	HIGH	Delivered at term, spontaneously.
3	3-6507	21	2	1	28	HIGH	Delivered at term, spontaneously.
4	3-8241	32	5	4	29	TOTAL	Home. Bled at 39 wks. Section for complete placenta previa.
5	4-1794	22	2	1	32	HIGH	Delivered at term, spontaneously.
6	4-3702	22	2	1	30	HIGH	No further bleeding. Premature labor at 33 wks.
7	4-6578	19	2	1	32	HIGH	Delivered at term, spontaneously.
8	4-7491	42	9	8	28	HIGH	Continued hospitalization for bleeding. Section at 31 wks., complete abruptio.
9	4-8713	30	6	4	35	LOW	Delivered at term, spontaneously.
10	4-8882	34	1	0	34	LOW	Section at 37 wks. for complete placenta previa.
11	5-0562	36	5	4	32	LOW	Delivered vaginally at 34 weeks.
12	5-1671	27	3	2	35	LOW	Section at 38 wks. for partial placenta previa.
13	5-3454	25	3	2	32	HIGH	Delivered at term, spontaneously.
14	5-4282	24	2	1	31	LOW	Section at 32 wks. for low-lying placenta.
15	5-6170	41	8	6	36	LOW	Delivered vaginally at 37 wks.
16	5-5827	22	1	0	30	LOW	Delivered at term, spontaneously.
17	5-8780	39	5	4	32	LOW	Section at 37 wks. for complete placenta previa.
18	5-9528	25	1	0	32	HIGH	Delivered at term, spontaneously.
19	6-0541	17	1	0	35	HIGH	Delivered at term, spontaneously.
20	<div style="display: inline-block; vertical-align: middle; font-size: 3em; line-height: 1;"> { out- patients del. at other local hospitals} </div>	30	3	2	36	TOTAL	Section at 37 wks. for complete placenta previa.
21		26	2	1	36	LOW	Bled during term vag. del. from low-lying placenta.
22		27	4	2	36	LOW	Section 37 wks. Marginal placenta previa.

Of the seven cases investigated on out-patient basis, after a transitory initial bleeding episode, two were diagnosed as TOTAL, three were LOW REACHING and two were HIGH. At the time of hospital delivery, three had Cesarean sections, one bled from a low-lying placenta, but was delivered vaginally; and three delivered uneventfully at term.

CASE REPORTS

The following three cases; No. 7, No. 17, and No. 4 of Table 1 are presented to show how each one was managed clinically in conjunction with the report of the isotope localization studies.

Hosp. No. 4-6578: 19-year-old white female, Gr. 2, Para 1, with EDC on Sept. 9, 1964. Entered hospital on July 19, 1964, at 32 weeks gestation because of vaginal bleeding with mild contractions. Three more episodes of bleeding in the next twelve hours with mild irregular contractions, then ceased.

Exam: Irritable uterus, fetal heart tones 140 in right lower quadrant. No vaginal examination. Isotope localization done on July 22, 1964.

R		L
2200	2603	2998
1978	2108	2504
2087	1900	2240

Localization Report: HIGH

Placenta at the left upper corner with extensions to the upper middle and the left lateral segments.

Further Course: Discharged on July 23, 1964; no further bleeding episodes. Spontaneous labor on Sept. 12, 1964, with delivery of 4 pound 3 ounce living infant. There was an old coagulum on the posterior surface of the placenta.

Comment: Clinically there was a possibility of abruptio placentae. The localization of the placenta in the upper segments ruled out placenta previa. The absence of symptoms after the first 12 hours of admission indicated that prolonged hospitalization probably would not benefit the patient.

Hosp. No. 5-8780: 39-year-old white female, Gr. 5, Para 4, with EDC on 12-23-65. Admitted 10-14-65 at 31 weeks gestation because of heavy vaginal bleeding. Heavy bleeding ceased shortly after admission. Isotope localization was done on 10-15-65.

R		L
3301	2487	2290
3431	2811	2273
3009	2628	2226

Localization Report:
LOW REACHING
Highest reading on three right sided segments; somewhat lower readings of middle central and middle lower segments. A right lower marginalis placenta extending toward the internal os.

Further Course: Bed rest at home on 10-16-65. Bleeding began again three weeks later, but ceased shortly after hospital admission. Infant considered too small; home after five days. Readmitted 21½ weeks later at 37 weeks gestation with mild bleeding which again ceased after admission. Cesarean section on following day with delivery of a 5 pound 7 ounce male; the placenta was on the right side of the uterus extending into the lower segment and covering the internal os, clinically a complete previa.

Comment: This patient was clinically assumed to have placenta previa from 31 weeks and treated accordingly. The patient was an intelligent nurse, living not too distant from the hospital, with someone constantly at home and transportation available. It was possible to follow conservative treatment without prolonged hospitalization until the infant was judged to be of adequate size for operative delivery.

Hosp. No. 3-8241: 32-year-old negro female, Gr. 5, Para 4, with EDC on 12-17-64. Hospitalized at 28 weeks for bleeding. Isotope localization done while as an out-patient at 29 weeks:

R		L
1687	1685	1750
2546	2180	2300
3141	2989	2754

Localization Report: TOTAL

Total placenta previa with bulk of placenta in the right lower and middle lower segments. Extensions to the left lower and right intermediate lateral segments.

Further Course: The patient bled again at 39 weeks and was hospitalized. Cesarean section was performed for total placenta previa with delivery of a living 9 pound infant.

Comment: This case had an absolute diagnosis of complete placenta previa early in pregnancy. By careful management at home it was possible to bring this patient to near term before operative delivery. This

patient's blood and plasma volume determinations are listed under METHODS. They were of added value in the management of this case.

Not all cases will end as ideally as these three. However, if isotope placenta localization is used as a diagnostic adjunct, it will supplement clinical judgment in the management of selected cases of third trimester bleeding.

Discussion

Being in an average-sized community hospital, our maternity service is in the 1000-1999 deliveries-per-year group of hospitals in the state of Illinois. This group of hospitals does about 30 percent of the deliveries in the state yearly.¹³

A number of our third trimester bleeding cases occur in the last three weeks of pregnancy, or with a sufficiently large infant, so that intracervical digital examination under "double set-up" suffices for diagnosis. Some additional cases never cease bleeding sufficiently to allow time for isotope localization. This leaves us with placenta localizations using I¹³¹ HSA done on a fairly infrequent basis. The high number of radioisotope diagnoses pointing out a low reaching placenta or total placenta previa indicates a good clinical selection of the patients by their attending physicians.

From the review of our cases, the diagnostic radioisotope technique had a high degree of accuracy. The basic requirement for any hospital to develop this technique would be the presence of a well-operated radioisotope service with qualified and interested personnel. If this requirement is met, radioisotope placentography will be utilized by more obstetrical departments as a desirable tool in the management of selected cases. The simultaneous blood and plasma volume determinations have been valuable in the selection of patients for transfusion or iron supplementation. These volumetric observations may serve as reference in other clinical problems involving obstetrical and gynecological patients.

Summary

1. Results of 22 placenta localizations over a two year period are presented from a community hospital.
2. We agree that placenta localization using I¹³¹ HSA is safe, simple, and has a high degree of accuracy.

3. The simultaneous performance of blood and plasma volume determinations has been quite useful in the evaluation of the hematological status of this type of patient.
4. The use of these diagnostic procedures is feasible in any hospital if there exists a radioisotope service with qualified and interested personnel.

We wish to thank Dr. John W. Seidlin, Chief, Department of Obstetrics and Gynecology, for his strong interest and his initiative in stimulating this line of investigation.

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Recent Progress in The Management of Rh Isoimmunization

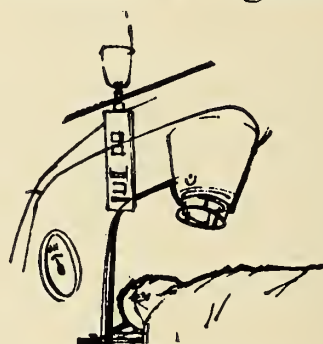
By ALLAN G. CHARLES, M.D., WILLIAM M. ALPERN, M.D. AND
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The specific, important interrelationships between a mother and her fetus resulting in Rh isoimmunization have become clarified only recently. This enlightened era began in 1940 with the discovery of the Rh factor^{26, 30} and its role in producing erythroblastosis fetalis.^{11-13, 28, 29} It was learned that the Rh factor in the fetus stimulated the development of the sensitization phenomenon in the Rh negative mother; the antibody she developed was transported back to the fetus,⁵⁰ there to effectively destroy its red blood cells and ultimately to produce the characteristic picture of hydrops fetalis.¹⁶ When it was demonstrated that severe neonatal jaundice was associated with kernicterus and neurological damage,^{10, 17, 18, 21, 23, 35, 36, 44, 49} the use of exchange transfusion in the newborn infant (to clear circulating bilirubin, to minimize jaundice, and thus to reduce the incidence of kernicterus) became widespread.^{2, 14, 15, 27, 37, 47, 52} The only obstetrical aspect of attack consisted of early recognition and pre-term delivery.^{5, 9} This approach was seriously limited because no clear-cut methods were available for reliable diagnosis or for defining severity.²² The outlook for the patient with Rh isoimmunization was quite bleak. It was likely that she would have more severely affected infants with each succeeding pregnancy.

Our basic objectives in this condition were and remain (1) prevention of intrauterine fetal death and (2) avoidance of permanent neurological damage in the newborn infant. Toward this end, until recently

the only available obstetrical measures as indicated were either premature induction of labor or elective cesarean section at a time chosen more or less arbitrarily according to the past obstetrical history of the patient and the presumed severity of the disorder in the current pregnancy.

Medical Progress



HARVEY KRAVITZ, M.D.
Medical Progress Editor

The overall assessment of the existence of sensitization and its intensity in a given pregnancy was founded upon evidence accumulated from several areas. These are outlined in Table 1. The past obstetrical history of the patient is quite important, particularly if she has delivered affected infants previously.^{1, 25} Information on the Rh factors of children born earlier, the severity of their disease, the gestational age at time of intrauterine death where this has occurred, and pertinent findings on autopsy, can be very helpful. Since one can anticipate progression of the disease with successive pregnancies, one can easily under-

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stand how important such detailed information is.

Determination of the husband's Rh genotype^{42, 43, 48, 51} is also important, as this may give information on heterozygosity, in much the same way as prior delivery of an Rh negative infant will (provided, of course, that the husband represents the biological father of both infants). Since timing of delivery is quite critical, wherever possible attempts should be made to estimate gestational age. Thus one should take into account menstrual history, documentation of normal uterine growth, date when fetal heart was first heard, estimation of fetal weight by abdominal examination, and measurement of fetal head size by x-ray cephalometry. Although all factors are subject to error, when examined together they may provide a reasonable, composite answer.

Table 1. Clinical Parameters for Evaluation

I. Past History

- Incompatible blood transfusion
- Outcome of previous pregnancies
 1. Rh factor of infant
 2. Severity of hemolytic disease
 3. Gestational age at intrauterine death
 4. Infant's autopsy findings

II. Determination of Husband's Rh Genotype

- Homozygosity: All infants expected to be Rh positive
- Heterozygosity: 50 percent chance of infant being Rh negative

III. Estimated Date of Confinement and Estimated Fetal Weight

- Timing of delivery may be critical
 1. Last menstrual period
 2. Uterine growth record
 3. Date fetal heart first observed
 4. X-ray cephalometry
 5. Abdominal examination

IV. Maternal Antibody Titers

- Limitation: May be no elevation or significant rise in titer in severe cases; rising titer in unaffected cases seen

- Reliability: Variable and unpredictable

V. Complications Requiring Modified Management

- Diabetes mellitus
- Toxemia
- Abruptio placentae
- Multiple pregnancy

The limitations of maternal anti-Rh antibody titers are well known.^{22, 24, 25, 38} At one extreme, antibodies may appear anamnestic in the absence of sensitization, or at the other, they may not rise significantly in severe cases. Thus although high or rising titers suggest the presence of Rh sensitization or of increasing sensitization, respectively, they cannot be relied upon.

Overall mortality from untreated erythroblastosis is of the order of 35 percent. This can be reduced to 25 percent by utilizing the above standard parameters of evaluation. Recognition of the problem, astute evaluation based on these factors, aggressive interruption of the pregnancy where indicated, improved care of the premature infant, and the introduction of exchange transfusion techniques for the newborn have resulted in these significantly diminished mortality rates and in the prevention of neurological damage from kernicterus in many instances.

The two problems which remain to be resolved are (1) how to determine the existence of hemolytic disease due to Rh isoimmunization and to measure its severity with greater accuracy, and (2) what to do with the infant so severely affected that he cannot survive in utero yet is too small to survive outside the uterus.

Amniocentesis

The first of these was resolved by the demonstration that the presence of blood pigments in the amniotic fluid was critically related to the severity of the hemolytic process.^{3, 4, 20, 31, 32, 45} Amniotic fluid is readily obtained by transabdominal amniocentesis. The fluid can then be analyzed for its blood pigment content by means of a spectrophotometer. In this way, a characteristic absorption curve is produced by plotting optical density against the wavelength of the visible light spectrum. As the destruction of fetal red blood cells progresses, there is an increase in the concentration of the various breakdown products of hemoglobin in the amniotic fluid. These pigments absorb monochromatic light between wavelength range of 400 to 500 mμ, and the cumulative peak effect is seen at 450 mμ.

This approach has been used to provide a realistic and practical index of the presence and severity of Rh isoimmunization. It

is quite clear that the benefit obtained must be balanced against its potential hazards. Nevertheless, significant reductions in perinatal mortality from 25 percent to between 6 and 10 percent have been documented.

Table 2. Schedule for Amniocentesis and Spectrophotometric Analysis

Initial
Usually 28-32 weeks
Earlier with history of early antepartum loss
Repeat
Every 2 to 3 weeks, or more often when indicated
Usually unnecessary if initial analysis is normal

The initial amniocentesis and analysis of amniotic fluid (Table 2) should be done between the 28th and 32nd weeks of pregnancy. For those patients who have lost infants from hemolytic disease at an earlier gestational age, the initial examination should be done at a time prior to that indicated by her history because it can be anticipated that sensitization will occur earlier and be more severe in later pregnancies. If the initial analysis demonstrates no peak in the critical range or only an insignificant one, additional analysis tends to be unnecessary. In other cases, amniotic fluid should be re-examined at two to three week intervals. With moderate to very abnormal peaks, repeat examination must be done more often.

The technique of amniocentesis has been simplified so that it requires only skin antiseptic solution, sterile towel, syringe and needle for local anesthetic infiltration, and syringe and 22 gauge, 3½ inch spinal needle for purposes of puncturing through the abdominal wall to enter the uterine cavity. The patient first empties her bladder and then is positioned on her back with her head slightly elevated. The uterus is palpated and the unobstructed area anterior to the baby's shoulder is located. The selected site is then prepared with antiseptic solution and infiltrated with local anesthetic agent. The puncture needle is deftly introduced into the amniotic cavity and fluid aspirated.

Fluid specimens are placed in clean test tubes and protected from light to avoid deterioration of pigments. The fluid is centrifuged for one half hour at 2000 rpm, and filtered. Analysis is carried out in a con-

tinuously recording spectrophotometer (we use a Model 11 Carey) and the height of the 450 mu peak is measured directly from the recorded spectral absorption curve in optical density units (Fig. 1).

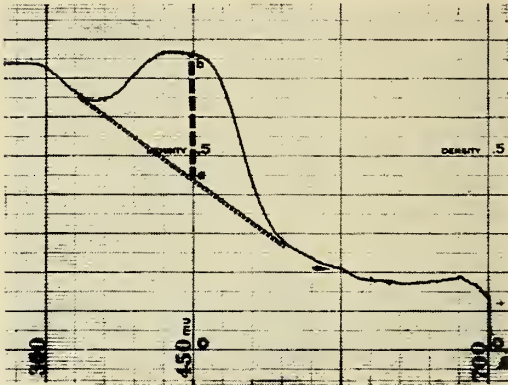


Fig. 1. Spectral absorption curve, optical density versus wavelength of light, showing bilirubin pigment peak at 450 mu. Measurement of height of peak above intrapolated baseline is demonstrated.

The technique has a wide margin of safety, but does present specific risks to mother and fetus. In our experience, complications have been minimal, but there have been reports of effects on maternal antibody titer,³⁹ and occasional maternal, placental, and fetal hemorrhage,^{31, 40} premature labor,³¹ infection and fetal damage.¹⁹ Thus the procedure should not be undertaken lightly.

The height and progression of the spectral absorption curve at 450 mu is critically important (Fig. 2). The negative curve of amniotic fluid signifies either that the baby is Rh negative, or it is an unaffected Rh positive infant, or is only so mildly affected by the hemolytic process that immediate intervention is unnecessary. Similarly, 450 mu peaks of less than 0.07 optical density unit in our laboratory requires expectancy only. In the middle range, peaks between 0.07 and 0.17 unit indicate that an Rh isoimmunization phenomenon of moderate severity exists. Under these circumstances, if the level does not rise into the more severe range, early termination of pregnancy around the 36th week seems in order. Peaks greater than 0.18 unit forecast the severe nature of the condition and the urgent need for action. Here we face the dilemma of risking fetal death or damage from erythroblastosis if delay occurs, or the real hazards of neonatal death from prematurity if pregnancy is interrupted too soon.

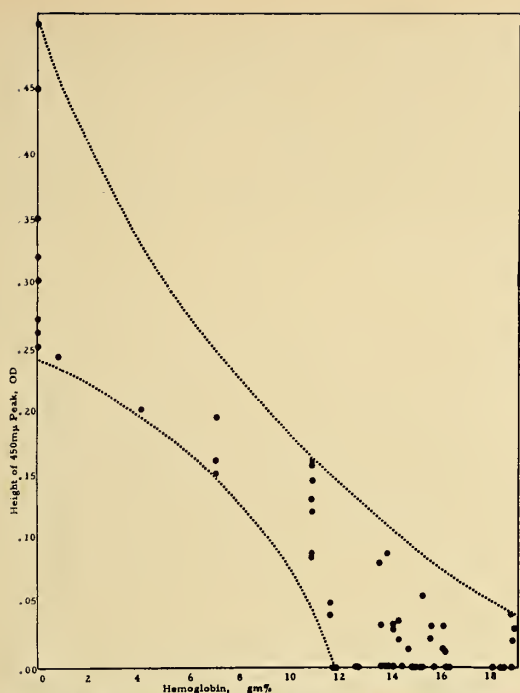


Fig. 2. Correlation between amniotic fluid spectrophotometric peak at 32 weeks' gestation or earlier and the expected cord hemoglobin in untreated infants delivered at 36 weeks or later. Low peaks forecast high hemoglobin levels, high peaks severe anemia.

We thus have a delicate technique which enables us to make rather clear-cut diagnoses of sensitization phenomena, both with regard to its existence and its severity. By means of quantitation,³ we can further relate the relative severity of the disorder to be expected in the newborn infant with the height of the peak at 450 mμ in amniotic fluid obtained prior to the 32nd week of pregnancy. A very good correlation exists between this peak and the cord hemoglobin level at birth (Fig. 3). The latter reflects both the intensity and the duration of the isoimmunization process in utero, the greater spectral absorption peak and the longer its duration, the lower the cord hemoglobin will be at the time of birth.

Using this information, we can proceed to think in terms of early termination of pregnancy in those cases where a meaningful compromise between urgent delivery and unavoidable prematurity is necessary. It is unfortunate, however, that we are still faced with the serious problem of the severely affected previable infant who could not possibly survive outside the uterus. There remain those pregnancies in which fetal involvement becomes so severe at such an early stage that extrauterine survival is

unlikely because of marked immaturity.⁴⁶ In these cases, if the fetus is left in the uterus without special attention to gain valuable time to mature, the outcome will invariably be intrauterine death or irreversible neurological damage.

Intrauterine Transfusion

Amniocentesis has been invaluable in determining those cases of isoimmunization in which the fetus will not survive to viability undamaged. In this situation, the technique of intrauterine transfusion may allow us to leave the fetus in utero for additional periods of time. The procedure of administering blood to the fetus by injection into the fetal peritoneal cavity is now well established.^{6-8, 33, 34, 41}

The technique consists of inserting a needle through the maternal abdominal wall, the uterine wall, the amniotic sac, the fetal abdominal wall, and into the fetal peritoneal cavity. It clearly requires a team effort and is simplified by the use of special x-ray monitoring devices. Radio-opaque material is injected into the amniotic cavity for purposes of amniography and, because the fetus actively swallows amniotic fluid, for demonstration of fetal intestinal tract (Fig. 3). In this way the site of the intestinal con-

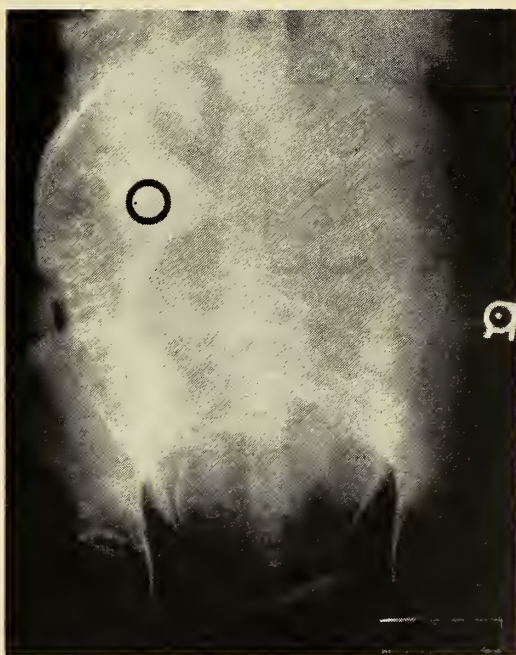


Fig. 3. Supine anteroposterior view of abdomen 5 hours after injection of radio-opaque contrast medium into amniotic cavity. Swallowed dye fills fetal intestinal tract. "O" marker indicates puncture site.

tents is located and serves as the target for puncture. When the needle has been inserted into the area of fetal intestines, additional radio-opaque dye is injected and, if correctly placed, a characteristic pattern of demilunes around the loops of bowel is seen (Fig. 4). Freshly drawn Type O, Rh negative packed red blood cells, compatible by cross matching with the mother's serum, are then transfused. The amount given is determined by the estimated fetal blood volume based on 15 percent of the fetal weight.



Fig. 4. Dye in fetal peritoneal cavity with characteristic demilune pattern showing proper location of needle for transfusion of blood to fetus.

The technique results in significant elevations of fetal hemoglobin, the injected cells entering the fetal circulation probably by way of the subdiaphragmatic lymphatics. The procedure can be repeated weekly or biweekly, depending upon the changing fetal needs due to continued destruction of its Rh positive erythrocytes and additional expansion of its circulation with further growth. The residual mortality cited earlier can be reduced 50 percent using this approach. Benefit is strictly limited to those infants whose disease has not progressed to the extreme form of hydrops fetalis. This state prevents the adequate absorption of infused blood from the peritoneal cavity and, therefore, expectation for survival of such an infant is negligible. It should be emphasized that this technique is not with-

out danger to the infant. Perforation of various organs, including stomach, intestines, bladder, and liver may occur. In consideration of the hopelessness of the situation for these infants, whether delivered prematurely or allowed to remain in utero without any form of therapy, these hazards can be readily accepted in these selected instances.

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Ileoptomists

(Continued from page 313)

on circumilostomy skin care, by Dr. Jean Spencer of Chicago on post-ileostomy diarrhea, and by Dr. Robert Feldman of Mt. Sinai Hospital, New York, on "Motherhood and the Ileostomist." The Ileoptomists also have circulated a series of articles prepared especially for their bulletin by Dr. Marshall Sparberg of the University of Chicago.

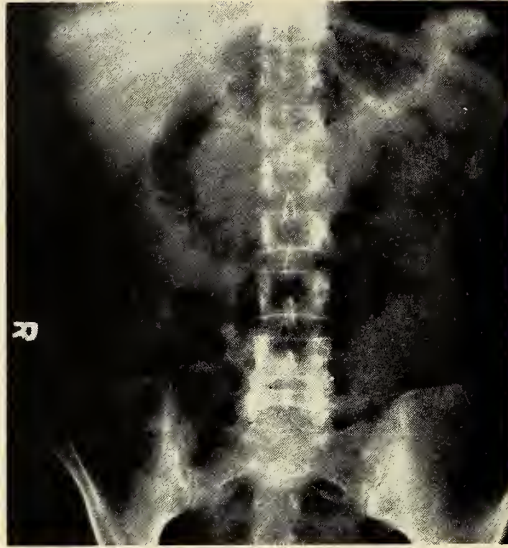
Medical advisors for the Chicago group include Joseph B. Kirsner, M.D., Samuel L. Andelman, M.D., Edward C. Holmblad, M.D., and Frederick Stenn, M.D. Meetings are held on the third Monday of the month at Wesley Hospital, and are open to all ileostomy patients and members of the nursing and medical professions. Physicians may arrange for patient visits by calling Mrs. Ann Nutter at HE 4-6756, or Mrs. Willard Sanders at RE 5-6551. Arrangements for panel presentations to hospital groups may be made by calling Mr. Maurice Ettelson at 966-6874.

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THE VIEW BOX



LEON LOVE, M.D.
DIRECTOR, DIAGNOSTIC RADIOLOGY
COOK COUNTY HOSPITAL

This 27-year-old male entered Cook County Hospital with a history of vomiting, severe abdominal pain, and obstipation for the past 24 hours. He had been in good health prior to his admission.

Physical examination revealed an acutely ill patient obviously in great distress. His abdomen was diffusely tender, and rebound tenderness was elicited particularly in the upper quadrants. A rectal examination failed to reveal the presence of stool.

White blood count—19,000 with 73 percent of polymorphonuclears. What's your diagnosis?

1. Sigmoid obstruction.
2. Acute pancreatitis.
3. Ruptured duodenal ulcer.
4. Superior mesenteric artery thrombosis.

(Answers on page 337)

—THE VIEW BOX—

DIAGNOSIS AND DISCUSSION

(Continued from page 329)

DIAGNOSIS: Acute pancreatitis.

The diagnosis of acute pancreatitis on scout film examination of the abdomen is suggested by the presence of the following findings.

- 1) Enlargement and medial compression of the gas filled second portion of the duodenum.
- 2) Note the reverse "E" in the mid-portion of the duodenal sweep.

Both of these signs indicate enlargement and edema of the pancreas and localized paresis of the bowel.

- 3) Colon "cut-off" sign. This is indicated by distension of the gas filled trans-

verse colon abruptly terminated at the level of the splenic flexure.

- 4) A triangular wedge shaped density between the gas filled stomach and transverse colon which tapers to the left side.

Both of these signs are attributed to the extension of peritonitis along the mesenteric attachments. The presence of small calcifications to the right of L2 in the projection of the body of the pancreas is another highly suggestive sign.

A serum amylase was obtained with a value of over 1000 Somogyi Units which confirmed the radiologic impression.

President's Page

(Continued from page 272)

were able to be rehabilitated and brought back to their normal existence.

I also feel resentful of the term that is being used of "Centers for the Care of Patients Suffering from Diseases of Heart, Cancer, Stroke and Related Diseases." I am not so sure as to what the term "related diseases" means. To me it is evident that the people who are in charge of these programs had in mind the "skin and its contents." I am sure that about 95 per cent of all diseases are included as related to heart, cancer and stroke. I don't believe that the original plan or the original meaning of these centers was to include all of the related diseases pertaining to the heart, cancer and stroke program.

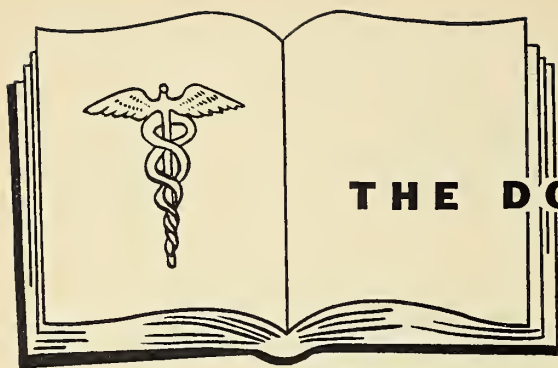
Again, I take objection to the term "care of the patient" because that means treatment and certainly we hope that these centers will not treat people, perhaps only to the extent to use the treatment as means of a research program. The medical society and the profession is willing to support these centers if the purpose would be to use them as a means of research and continuing education of the doctors and the lay-people. I, therefore, suggest that the H.E.W. and the office of the President clarify the term "related diseases" so that it will remove all doubt as to the purpose of

these centers and also to define the term "care" so that we would understand their aims and purposes.

After having spent several days at this conference, it is my opinion that we recommend to the President and Surgeon General that the efforts of these centers should be:

1. As a center for education of the public, to motivate them and to obtain for them good medical care.
2. That the President recommend that the regional centers select directors approved by official medical societies in each area.
3. That construction of these facilities should be the decision of the local autonomy.
4. That the President make it clear that this program is not to interfere with the private practice of medicine. That the doctors would use these centers as means of promoting research and continuing education. Finally, that our purpose and the purpose of the government should be definitely spelled out that it is to sustain and insure good medical care of the public.

Caesar Portes, M.D.



THE DOCTOR'S LIBRARY

VITREORETINAL PATHOLOGY AND SURGERY IN RETINAL DETACHMENT. Paul A. Cibis, M.D., St. Louis, C. V. Mosby Company, 1965. Clothbound, 264 pages, 277 figures in black and white, 15 tables, extensive bibliography, subject index. Price \$20.

This monograph is the last work of the late Paul Cibis, a skilled and remarkably ingenious ophthalmic surgeon who was a leader in the surgical attack upon abnormalities of the vitreous and with particular emphasis on the treatment of complicated retinal detachments.

The monograph is divided into two parts. Part I deals with vitreo-retinal pathology in retinal detachment. Part II describes techniques of vitreoretinal surgery.

In Part I the author attempts to appraise the present knowledge and conception of vitreoretinal pathology in complicated types of retinal detachment. He reviews the anatomy and chemistry of the normal vitreous and its relationship to adjacent structures. Experimental changes in the vitreous observed by the author as well as by others are described. The effects of mechanical, chemical, and thermal trauma as well as radiogenic, osmolar and immunochemical reactions are discussed.

The remainder of Part I deals with clinical observations ranging from maldevelopmental to hereditary and degenerative vitreoretinal changes. In Part II the author's surgical techniques for intra vitreal surgery are described in detail. Complications and results of these techniques are discussed.

For those ophthalmic surgeons who are challenged by patients who exhibit advanced vitreoretinal abnormalities, this monograph provides a good background for surgical attack on the vitreous.

J. GRAHAM DOBBIE, M.D.

A PRIMER OF ELECTROCARDIOGRAPHY, by George E. Burch, M.D., and Travis Winsor, M.D. 364 pages. Lea & Febiger, Philadelphia, \$6.50, 1966.

This book, now in its fifth edition, has enjoyed tremendous popularity with those who desire to learn the fundamentals of electrocardiography. The authors have been eminently successful in presenting the basic concepts of electrocardiography in a clear, concise, and relatively simple fashion that has made this book so popular for the beginner since the first edition appeared in 1945.

The format and presentation are basically unchanged. True, there are some minor changes as admitted by the authors in the preface. I heartily agree with their postponement of any specific changes in vectorcardiography because of lack of advancement in this field. Controversy still is going on in regard to the value of this technique in the clinical application of its principles.

I can only reiterate the favorable comments of previous reviewers by highly recommending this book to beginners in electrocardiography. It will serve them excellently in their studies of this field and will help to establish a firm foundation upon which their future knowledge can be added.

MAURICE GORE, M.D.

THE OCULAR FUNDUS IN NEUROLOGIC DISEASE, A DIAGNOSTIC MANUAL AND STEREO ATLAS. William Fletcher Hoyt, M.D., and Diane Beeston, Medical Photographer. 137 photographic illustrations, 98 stereoscopic views in full color on 14 View Master® reels, and a View Master® compact viewer, 127 pages. C. V. Mosby Co., St. Louis, 1966, \$35.

This diagnostic manual presents vivid

clinical photographs of fundus alterations in the living patient. These views are seen in three-dimension, full color, 98 stereoscopic pictures of normal variations, anomalies, and pathologic changes in the optic disc and adjacent retina, in a manner which cannot be duplicated by ordinary photography or even with the hand ophthalmoscope. In addition, the manual includes 137 black-and-white photographic illustrations keyed to the stereo reels; a collapsible stereoscopic viewer accompanies the book and conveniently fits into the back of the atlas. A well-written clinical discussion of the neurologic diseases and their ocular manifestations runs concurrently with each illustration. The work is a sound, clinically-oriented academic endeavor of merit.

The division of the contents is geared to the basic needs of the clinician: papilledema

and all its variations; confusing elevated-disc anomalies often misdiagnosed papilledema; disc swellings from local and systemic disease; pallor of the optic disc—differential diagnosis; and combined disorders of the retina and brain—retino-cerebral syndromes. This stereoscopic atlas would be particularly valuable in every ophthalmic and neurologic teaching institution, and in every medical library. It is an excellent study manual for ophthalmic and neurologic residents. It is a delightful and rewarding presentation, in living color and in stereoscopy, of ocular fundi for the general practitioner and surgeon who hankers for a true appearance of the optic nerves in relation to neurologic disease, in all their variations, normal and pathologic.

Jack P. Cowen, M.D.

New Film on Microbiological Safety

A 35-minute movie in color, "Laboratory Design for Microbiological Safety," has been released by the Public Health Service for use by individuals and groups interested in the problem of protecting laboratory workers studying highly infectious materials.

The idea for the 16 mm film came from the National Cancer Institute, National Institute of Health, where concern has been high for the safety of scientists engaging in rapidly expanding studies of the Institute's

Special Virus-Leukemia Program. Engineering principles involved in the design and construction of buildings which can safely house microbiological research are highlighted, and the concept of primary and secondary barriers in the containment of microorganisms is stressed in the film.

The film (CDC Number M-1091) is available on loan from the Communicable Disease Center Library, Atlanta, Ga. and the Biohazards and Containment Section, National Cancer Institute, Bethesda, Md.

Pentazocine

(Continued from page 322)

pentazocine provided excellent relaxation insofar as the patient was cooperative, less anxious and was relatively free of pain. Arteriograms, trephining of skulls, carotid endarterectomies, D & C's, and cystoscopies were well controlled with pentazocine.

Thirty milligrams was the most frequently used dose while 60 mg. was used in approximately 16 percent of all cases. Both doses were well tolerated and produced Good to Excellent rated analgesia in 85 percent of the cases. Results in 51 pediatric cases showed pentazocine to have a high order of effectiveness with the 30 mg. dose. As a premedicant, 30 mg. pentazocine combined with 50 mg. hydroxyzine yielded a high percentage of relaxed, calm and co-operative pre-surgical patients.

On the basis of clinical experience with 585 patients it is concluded that pentazo-

cine provides a high degree of analgesia postoperatively and affords surgical patients adequate preoperative preparation.

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EDITORIALS



THINGS TO COME

We are beginning to sense renewed activity in Washington for new regulations dealing with the practice of Medicare. There are more and more discussions and messages dealing with children and youth which leads us to believe that one of organized medicine's objections to Medicare is about to materialize. The administration's fight for socialized medicine settled for the care of the elderly (and medically indigent) but many of us regarded this law as only the foot in the door. What was there to prevent lowering the age limit to 60 or 50 years or to include infants, children, and our youth?

Prior to the passage of the Medicare bill (and Title 19) there was well-planned propaganda, paid for and directed by the so-called liberal elements in our country and in Washington. This is no secret and the method for this and related legislation follows a similar pattern. There is increasing evidence that it is starting all over again by creating and publicizing problems in the care of infants even during the prenatal period. The President is convinced that the federal government has a responsibility to help diagnose and treat medical problems early, even in the very first part of life. He ignores the job already accomplished by the medical profession.

But this is only a small part of growing unrest in Washington. Medical manpower also is under heavy and persistent criticism. The President is calling for 10 pilot centers

to develop "more efficient methods and techniques of health care delivery" and "to train new types of health workers." He wants a physician assistant, someone between a registered nurse and that of a physician.

With Medicare, their foot is in the door and the administration now claims that its interest must be protected and that "its" money is wisely spent.

Let's face it. The climate is changing and the full impact of the aged under Medicare and those receiving public assistance has not yet been felt by most independent physicians. There are millions of voters in these groups and they are well organized with leadership. Capital Hill is listening to them and their demands are getting a sympathetic ear. The entire practice of medicine may be changed because of government's new interest in "health depressed areas—the urban ghetto and rural depressed regions." Apparently, the type of care that these people receive now is not enough and those in power have no choice but to do something even though it may be second rate and very costly. And they are going to hurry because they do not trust the will of the majority at our next election.

Medical practice has changed before and may change again. Most physicians are too absorbed in the practice of medicine to protect their interests as a citizen, but something is going to give unless they do.

T. R. Van Dellen, M.D.

REACTIONS FOLLOWING LIVE MEASLES IMMUNIZATION AFTER KILLED MEASLES VACCINE

Serious local and general reactions to live measles vaccine or to the natural disease in children who were previously given "killed" measles virus vaccine was reported by Fulginiti, Kempe and their co-workers.¹ They describe a group of 30 children who were given two doses of "killed" measles vaccine and one dose of live attenuated measles virus vaccine one month later. They received a dose of live attenuated measles virus vaccine four to five years later because of declining antibody levels and the development of measles in the group.

Two to five days after injection 50 percent developed a local reaction at the site of inoculation with induration, erythema, heat and tenderness. The reactions lasted from one to seven days and fevers of 101°-105° F. were common. Doctor Fulginiti believes these reactions are due to an altered reactivity to the measles virus of either the arthus or to delayed sensitivity. The re-

actions only occur after previous inoculation with killed measles virus vaccine.

In a recent meeting of the International Conference on Viral Vaccines reports of severe local and general reactions were given by Swedish and American investigators. The reactions occurred in children who had received the killed measles virus vaccine or those who subsequently contracted measles. Symptoms included fever, pneumonia, edema, myalgia, and rashes such as urticarial lesions, purpura, and petechiae.

These findings are presented to alert physicians who gave their patients killed measles vaccine and plan to give live attenuated measles virus vaccine in the future.

Harvey Kravitz, M.D.

Reference

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EXUDATIVE TONSILLITIS VIRAL AND BACTERIAL

Children under the age of three having exudative tonsillitis seldom have positive cultures for beta hemolytic streptococci. In a study of exudative tonsillitis in 47 children under three years of age, Joel Alpert and others found only seven or 14.6 percent to have streptococci. Some of these positive cultures may represent a carrier state since they did not differentiate between active infection and the carrier. Only one patient had a rise in the ASO titer.

Virus cultures were done in 27 cases revealing adenoviruses in six cases. Dr. Alpert mentions the difficulty in growing viruses in this series of cases. He believes that the present techniques for isolating viruses may not be developed sufficiently to recover a majority of the viruses capable of causing exudative tonsillitis.

He concludes that children with exudative tonsillitis usually do not require antimicrobial therapy unless there is proof by culture of the presence of beta hemolytic streptococci or if there is an associated otitis media.

Dr. Alpert did not study recurrent viral or bacterial exudative tonsillitis, but the paper brings several questions to mind concerning this problem.

Why do some children get recurrent exudative viral tonsillitis? What is being done to develop vaccines and chemotherapeutic agents effective in treating or preventing virus exudative tonsillitis? What progress has been made in developing rapid inexpensive cultures for the doctor in private practice who sees this common disease? How often are tonsillectomies and adenoidectomies done for cases of recurrent virus exudative tonsillitis and does the procedure result in fewer recurrent infections of the pharynx?

The management of exudative viral tonsillitis will remain a therapeutic wasteland until more research in this common condition is carried out. Until we get answers to some of these questions we can have only opinions of the treatment of recurrent virus infection of the tonsils and adenoids.

Harvey Kravitz, M.D.



Northwestern Scientist Reports First Successful Transfer of Allergic Asthma from Man to Monkey

The first successful transfer of allergic asthma from Man to monkey was reported last month at the annual meeting of the American Academy of Allergy by a Northwestern University immunologist.

Dr. Roy Patterson, professor of medicine at Northwestern University's Medical School in Chicago, presented both a description of the phenomena and a film showing the asthmatic response of monkeys.

As a result of the studies, medical scientists now have available experimental animals, close to Man in the evolutionary scale, for investigations of asthmatic allergic reactions.

The presentation was the first public or professional description of the asthma transfer technique since its development began in 1964. To date, 10 monkeys have contracted this experimental type of asthma.

The technique works in this manner:

Blood serum is obtained from human volunteers who are allergic to ragweed. Injected into a monkey, the serum transfers human antibodies to the animal's respiratory tract. When the sensitized monkey inhales air containing ragweed pollen or a spray of pollen extract, the classic symptoms of asthma develop—spasm, interference of air flow, difficulty in breathing.

The human antibodies are believed to sensitize cells in the monkey's bronchial lining, Dr. Patterson said. When the ragweed pollen contacts the cells, histamine and perhaps other chemical substances causing allergic inflammation of the bronchial tubes are released.

Dr. Patterson and his associates in the medical school's allergy section have also studied the problem of allergy in dogs since 1958.

Working with him in the monkey studies were Dr. Jacob J. Pruzansky, Dr. David Cugell, Dr. Leslie Reynolds and Dr. Lou Kettel. Dr. Terumasa Miyamoto, a co-worker in the development of the technique, is presently at the University of

Tokyo.

The research is supported by the Ernest S. Bazley Asthma Research Grant to Chicago Wesley Memorial Hospital, a Northwestern-affiliated hospital.

New Policy Set for Distribution of Gamma Globulin

The Illinois Department of Public Health has announced a new policy for the distribution of gamma globulin. According to Dr. Franklin D. Yoder, director, a more stringent policy was necessitated by the discontinuance of supply from the American National Red Cross.

The Red Cross previously allocated gamma globulin to the department for free distribution to physicians. The amount of the allocation was in direct proportion to the support given the blood donor program in Illinois.

Due to needs of overseas servicemen, the demands today are exceptionally high. In view of the heavy demand for the product and the limited supply available, the Red Cross has found it necessary to establish priorities for the distribution of gamma globulin. It will no longer be supplied free of charge to the states. The Red Cross will continue to supply gamma globulin without cost for disasters, epidemics and approved research.

"The department will continue to provide gamma globulin to the extent of its budget and in accordance with previously established gamma globulin policies," Dr. Yoder said. "These procedures will be maintained, limited only by budgetary considerations, on a replacement basis."

The department provides gamma globulin without charge to Illinois physicians requesting it for certain contacts to measles, German measles and infectious hepatitis.

Gastroenterology Competition

The American College of Gastroenterology, in cooperation with William H. Rorer, Inc., Ft. Washington, Pa., has announced the 1967 Rorer awards contest for the best papers in gastroenterology.

(Continued on page 349)



Some 75 Illinois physicians and their wives traveled to Washington, D. C., Jan. 30-31 to participate in the annual Association Public Affairs Conference. An hour with Illinois' senior senator, Everett Dirksen, dinner and receptions with their congressmen, inside information from top reporters, authors and scholars, and a chance to give their views to Illinois lawmakers in Washington were highlights of the trip. Shown here with Sen. Dirksen (center) are Theodore Grevas, M.D., Rock Island, chairman of the Illinois State Medical Society Public Affairs Committee; Jacob E. Reisch, M.D., Springfield, ISMS secretary-treasurer; Newton DuPuy, M.D., Quincy, president-elect of the society, and V. P. Siegel, M. D., East St. Louis, chairman of the ISMS Legislative Committee.

Tuberculosis

(Continued from page 319)

ate uncooperative single men. All of these require much attention from medical, nursing and rehabilitation personnel and have prolonged hospitalization periods and relatively poor results when compared with the remainder of the patients. A hopeful aspect is the marked reduction of children, adolescents and young adults in the sanitarium population and the decreasing number of beds required for Chicagoans.

1. Reid, Katherine: A Tuberculosis Sanitarium Surveys Its Changing Population, *Journal Rehabilitation*, May 1958.

News & Announcements

(Continued from page 342)

Awards will be presented for the best unpublished papers in gastroenterology or an allied subject and for the best paper published in the American Journal of Gastroenterology. In the first category, papers must represent original work and must not have been previously presented at meetings of any national society. Prizes in the second category will be for papers published during the 12 months ending June 30, 1967.

First, second and third prizes, totaling \$2,000 in cash plus journal subscriptions, will be awarded in each category.

June 15 is the deadline for entries, which should be addressed to the American College at 33 W. 60th St., New York 10023.

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**for multiple contraceptive action that has
produced a record of unexcelled effectiveness**

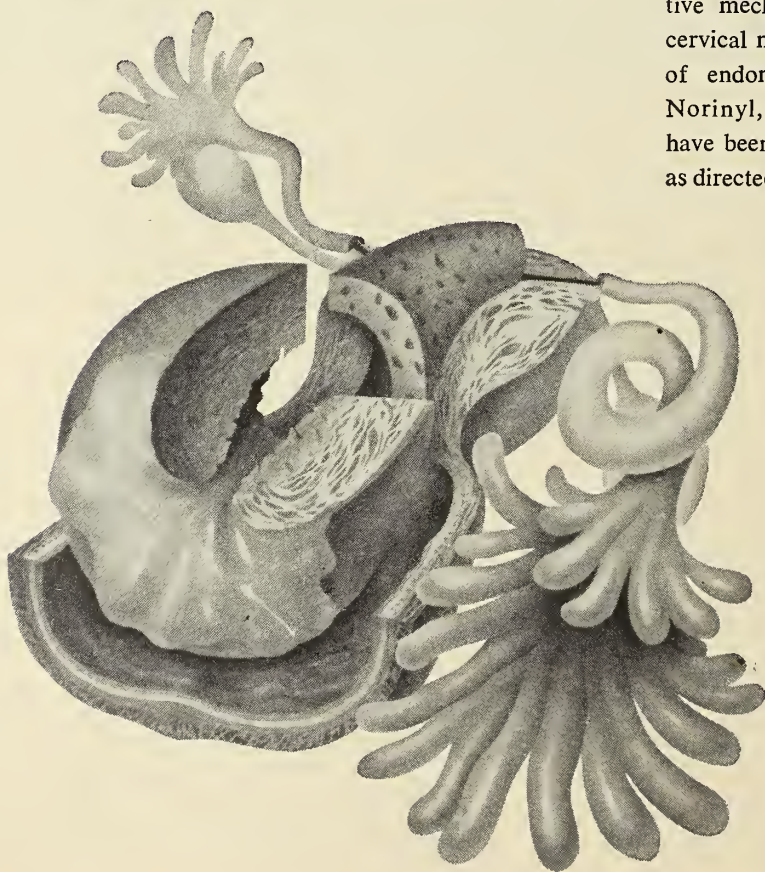
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sperm motility and vitality**

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to egg implantation**

no unplanned pregnancies

Norinyl provides multiple action for maximum assurance of success. It does not depend on ovulation inhibition alone for contraceptive effectiveness. The mechanism of action of combined hormonal therapy results in ovulation inhibition reinforced by other protective mechanisms, including a hostile cervical mucus¹⁻¹³ and an acceleration of endometrial changes.^{1-3,7-16} With Norinyl, no unplanned pregnancies have been reported to date when used as directed.



special formula for a special problem

*specifically formulated
for symptomatic
relief of sinus headache*

Sinus headache is not a single entity, but a chain reaction of pain. It is facial pain—deep, dull, aching and nonpulsating. It is referred pain—originating in the nose and sinuses but felt at another site. It may become generalized pain and tension in head and neck. It is one or all of these.

The Sinutab formula is designed for symptomatic relief of sinus headache.

It provides two analgesics to relieve pain and discomfort... an effective oral decongestant to reduce mucosal congestion... and an antihistamine to help control allergic manifestations.

Side Effects: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs.

Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

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Morris Plains, N.J.



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citrate.

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Sinus
sphenoidalis

Os
occipitale

The HOSPITAL OF CHOICE

North Shore Hospital, a 65-year-old psychiatric facility located on Lake Michigan in Winnetka, Illinois, is an intensive care hospital.

An open staff institution, it provides, through its house and attending staff, a total range of psychotherapies and those related activities which round out a comprehensive treatment program.

A new Half Way Hall, situated in the hospital, has been opened to provide relative freedom of movement in an environment designed to stimulate recovery and provide a necessary phase of interim residence.

A completely open section is a feature of North Shore Hospital's residential plan.

An adolescent program offers boys and girls of high school age a closely-structured program of daily care, with daily classroom attendance and individual tutoring emphasized.

The adjunctive therapies are manned by certified personnel. Occupational and recreational activities not only help structure the patient's day, but offer creative programs in which patients participate according to their emotional health and native capacity.

A therapeutic education program has been introduced for all patients. Medicare patients are offered special attention and remotivation activities.

Psychiatric testing and evaluation is offered, as is individual and group therapy, chemotherapy and the traditional modalities employed in the treatment of emotional illness.

In reputation, performance and location, North Shore Hospital is the psychiatric hospital of choice.



For information, contact:
MILTON A. DUSHKIN, M.D.
Medical Administrator
Telephone: 312-446-8440
225 Sheridan Road, Winnetka, Illinois
(Write for Brochure)

MEETINGS

Mar. 20-24—The American College of Physicians will sponsor a five-day postgraduate course on "Fundamental Concepts of Gastroenterology" at the University of Michigan Medical School, Ann Arbor.

Mar. 27-31—The American College of physicians and Wayne State University School of Medicine will present "Psychiatry for the Internist" at the Lafayette Clinic, Detroit, Mich. Register with Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Mar. 29—Dr. Sol Spiegelman, renowned microbiologist and lecturer, will deliver the annual Gehrman Lecture at 1 p.m. in the Chicago Room of the Chicago Illini Union, 828 S. Wolcott Ave., Chicago. His subject will be "The *In Vitro* Synthesis of Infections Viral RNA and an Analysis of the Mechanism."

Apr. 3-7—The Gill Memorial Eye, Ear and Throat Hospital and the Elbyrne G. Gill Eye and Ear Foundation, Roanoke, Va., will present their 40th spring congress in ophthalmology, otolaryngology and allied specialties at the Hotel Roanoke.

Apr. 4-5—The Cleveland Clinic Educational Foundation announces a postgraduate continuation course in gastroenterology entitled, "Diagnostic Procedures in Gastroenterology," to be conducted at 2020 E. 93rd St., Cleveland.

Apr. 5-7—The National Methodist Convention on Medicine and Theology, sponsored by the Council of Bishops and the Board of Hospitals and Homes, Board of Christian Social Concerns, the National Division of the Board of Missions, and the Commission on Chaplains, will be conducted in Rochester, Minn. Register through National Methodist Convocation, P. O. Box 102, Rochester 55901.

Apr. 6-7—An intensive program on "Auscultation of the Heart, Phonocardiography and Pulse Tracings," with special emphasis on the practical clinical applica-

(Continued on page 358)

Mediatric®

Designed for the “metabolically spent”

Nutritional reinforcement for those who can’t – or won’t – eat properly...balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes...mild antidepressant for a gentle “mood” uplift...

The estrogen component in MEDIATERIC is **PREMARIN®** (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATERIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a gentle “mood” uplift through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDIATERIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.
Contains 15% alcohol	

MEDIATERIC Tablets and Capsules

Each MEDIATERIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares’ urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATERIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

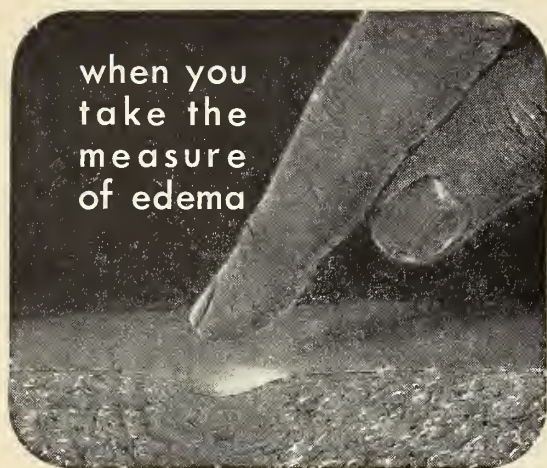
SUPPLIED: No. 910 — MEDIATERIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 — MEDIATERIC Tablets, in bottles of 100 and 1,000. No. 252 — MEDIATERIC Capsules, in bottles of 30, 100, and 1,000.



Mediatric®
steroid-nutritional compound

AYERST LABORATORIES, NEW YORK, N. Y. 10017 • Montreal, Canada





when you
take the
measure
of edema

... introduce your patient to **aQUATAG**® (BENZTHIAZIDE)

AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.



**S.J. TUTAG
& COMPANY**

Detroit, Michigan 48234

Meetings

(Continued from page 354)

tions, is being offered by the Institute for Cardiovascular Diseases at Good Samaritan Hospital, Phoenix, Ariz. Meetings will be held at the Mountain Shadows Resort in Scottsdale. Register through William D. Nelligan, Executive Director, American College of Cardiology, 9650 Rockeville Pike, Washington, D. C. 20015.

Apr. 7—Dr. Edward R. Annis, past president of the American Medical Association, will address the Association of American Physicians and Surgeons at a 7 p.m. banquet in the LaSalle Hotel, Chicago. His subject will be "After Nine Months of Medicare—A Critical Appraisal."

Apr. 8-9—The sixth American Psychiatric Association Colloquium for Postgraduate Teaching of Psychiatry will be conducted at the Safari Hotel, Scottsdale, Ariz. Register through William F. Sheeley, M.D., Arizona State Hospital, 2500 E. Van Buren St., Phoenix, Ariz. 85008.

Apr. 10-13—The 1967 American Industrial Health Conference will be held at the Americana Hotel, New York City. Register through American Industrial Health Conference, 55 E. Washington St., Chicago 60602.

Apr. 11-14—The 31st annual postgraduate institute of the Philadelphia County Medical Society will be conducted at the Bellevue-Stratford Hotel, Philadelphia, Pa. Subjects to be covered include diseases of the stomach and duodenum, genetically determined diseases, newer concepts in hypertensive cardiovascular disease, new horizons in thyroidology, cerebrovascular diseases, recent advances in ophthalmologic diagnosis, physical diagnosis from the standpoint of the skin, disease of coagulation and the use of anticoagulants, and acute pulmonary insufficiency. Send inquiries to 2100 Spring Garden St., Philadelphia 19130.

Apr. 12-13—The University of Wisconsin Medical Center and University Extension are presenting their second annual postgraduate conference on sports medicine at the Wisconsin Center in Madison. Register through Thomas C. Meyer, M.D., Assistant Dean, Department of Postgraduate Medical Education,

(Continued on page 361)

Trisulfaminic continued

ADVANTAGES: The advantages of Trisulfaminic in upper respiratory infections are: palatability of suspension; freedom from narcotics or alcohol; therapeutic reliability; safety; economy; ease of administration; freedom from potential sensitization to broad-spectrum antibiotics which may be reserved for lower respiratory or other infections caused by susceptible organisms. **CONTRAINDICATIONS:** Contraindicated in sulfonamide and antihistamine sensitivity, impaired renal function, pregnancy approaching term, and in premature infants and newborn infants during the first month of life. Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. **WARNING:** Use only after careful evaluation in patients with liver or renal damage, urinary obstruction, or blood dyscrasias. Deaths have been reported from hypersensitivity reactions with administration of sulfonamides. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed periodically. Sulfonamide therapy may potentiate the hypoglycemic action of sulfonylureas. **PRECAUTIONS:** Use with caution in patients with histories of significant allergy or asthma. Assure an adequate fluid intake. Because the antihistamines may cause drowsiness of varying degree, warn patients about activities requiring alertness such as driving a car or operating dangerous machinery. Use with caution in the presence of hypertension, hyperthyroidism, cardiovascular disease and diabetes. **ADVERSE REACTIONS:** As in all sulfonamide therapy, the following reactions may occur: headache, nausea, vomiting, diarrhea, icterus, hepatitis, pancreatitis, urticaria, rash, fever, cyanosis, hematuria, crystalluria, proteinuria, blood dyscrasias, petechiae, purpura, neuropathy and injection of the conjunctiva and sclera. If one or more of these reactions occur, the drug should be discontinued. With antihistaminic therapy there have been reports of sedation varying from mild drowsiness to deep sleep, dizziness, lassitude, inability to concentrate, fatigue, incoordination, tinnitus, blurred vision, diplopia, euphoria, nervousness, insomnia, tremors, palpitation, hypotension, headache, chest tightness, urinary frequency, dysuria, tingling of the hands, dryness of the mouth, throat, and nose, gastrointestinal disturbances such as epigastric distress, anorexia, nausea, vomiting, constipation and diarrhea and very rarely, leukopenia and agranulocytosis. Adverse reactions reported with the use of sympathomimetic amines include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesicle sphincter spasm. **PACKAGE INFORMATION:** Trisulfaminic Tablets: Supplied in bottles of 100 tablets. **CAUTION:** Federal law prohibits dispensing without prescription.

DORSEY LABORATORIES

a division of The Wander Company
LINCOLN, NEBRASKA

(Continued from page 358)

Room 302, 333 N. Randall Ave., Madison 53706.

Apr. 14-16—The American Fertility Society announces that the following awards will be made at its annual scientific meeting at the Hotel Shoreham, Washington, D. C.:

Ayerst Lecture Award to an outstanding international scholar in the field of reproductive biology; Carl G. Hartman Grant-in-Aid to an Ob-Gyn resident to meet expenses of attending scientific meetings; the I. C. Rubin award to the author of the most significant paper published in the *Fertility and Sterility Journal*; the Ortho medal for outstanding contributions in the field; the Samuel L. Siegler Lecture award to an outstanding physician and/or scientist in the field, and the Upjohn Lecture award in veterinary science.

Apr. 24-26—The 4th AMA Congress on Environmental Health Problems will be conducted at the Americana Hotel in New York City. Sponsored by the AMA's Council on Environmental and Public Health, Department of Environmental Health, and Division of Socio-Economic Activities, in cooperation with the Medical Society of the State of New York, the New York State Action for Clean Air Committee, and New York State Health Department, this congress will explore concepts, functions and responsibilities involved in the development of integrated research programs and the full utilization and effective coordination of our professional, administrative and technological resources. Emphasis will be placed on regional operations and the application of imagination and advanced technology.

Apr. 26-27—The Cleveland Clinic Educational Foundation announces a postgraduate continuation course in endocrinology entitled "Diabetes Mellitus: the Old and the New" to be conducted at 2020 E. 93rd St., Cleveland.

Apr. 27-28—The American Heart Association's Council on Cardiovascular Surgery and the Illinois Heart Association, in cooperation with the Chicago Heart Association and the Illinois Department of Public Health, will present a conference on assisted circulation immediately preceding the Apr. 28-29 annual meeting of the Illinois Heart Association at the Hotel Jefferson in Peoria.

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Tandearil®
oxyphenbutazone

helps osteoarthritic
joints move again



3 out of 4 osteoarthritics com-
pletely or markedly improved

76.9% of 407 patients

84.6% of 39 patients

Please see ad-
joining page for
brief prescribing
summary.

Sperling, I.L.: 3 Years' Experience
with Oxyphenbutazone in the
Treatment of Rheumatic Disorders,
Applied Therapeutics 6:117, 1964.

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TA-4919 PC

Tandearil®

oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Crippled Children's Clinics

Twenty-seven clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing service. There will be six special clinics for children with cardiac conditions and rheumatic fever and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

- April 4, Quincy—Blessing Hospital
- April 5, Alton Rheumatic Fever & Cardiac—Alton Memorial Hospital
- April 5, Rock Island Cerebral Palsy—Foss Home, 3808 Eighth Avenue
- April 5, Hinsdale Sanitarium
- April 6, Flora—Clay County Hospital
- April 6, Cairo—Public Health Building
- April 6, Lake County Cardiac—Victory Memorial Hospital
- April 11, East St. Louis—St. Mary's Hospital
- April 11, Peoria General—Children's Hospital
- April 12, Champaign-Urbana—McKinley Hospital
- April 13, Macomb—St. Francis Hospital
- April 13, Springfield General—St. John's Hospital
- April 14, Evanston—St. Francis Hospital
- April 14, Chicago Heights Cardiac—St. James Hospital
- April 18, Belleville—St. Elizabeth's Hospital
- April 19, Mt. Vernon—Good Samaritan Hospital
- April 19, Chicago Heights General—St. James Hospital
- April 20, Bloomington—St. Joseph's Hospital
- April 20, Rockford—Rockford Memorial Hospital
- April 20, Elmhurst Cardiac—Memorial Hospital of DuPage County
- April 25, East St. Louis—St. Mary's Hospital
- April 25, Peoria General—Children's Hospital

(Continued on page 364)

Crippled Children

(Continued from page 363)

- April 26, Springfield Cerebral Palsy (P.M.)—Clinic site to be announced
- April 26, Metropolis — Methodist Educational Bldg.
- April 26, Aurora—Copley Memorial Hospital
- April 27, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital
- April 28, Chicago Heights Cardiac — St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the Na-

tional Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Malrotation of the Intestine

(Continued from page 304)

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OBITUARIES

***Dr. Alfred Ash**, Mendon, died Jan. 13 at the age of 54. He practiced medicine for more than 25 years.

***Dr. Blanchard M. Baird**, Marissa, died Jan. 19 at the age of 67. He was on the staff of St. Elizabeth and Memorial Hospitals in Belleville, St. Clement Hospital in Red Bud, and Sparta Community Hospital. As a navy doctor holding the rank of commander in World War II, he served on the aircraft carriers, Essex, and Core. He was a member of the United Presbyterian Church of Marissa and the Robert Arnold Post, American Legion.

***Dr. Lindsay E. Beaton**, former Chicago physician, died Feb. 8 in Arizona where he has been living for several years. He was 56. A former chairman of the Mental Health Council of the American Medical Association, he was a past president of the Arizona State Medical Association and a psychiatric consultant to the Social Security Administration.

***Dr. William W. Cutter, Sr.**, Peoria, died Jan. 22 at the age of 85. He was past president of the Peoria Medical Society and a member of the American Heart Association, the Ivy Club of Peoria, and The ISMS Fifty-Year Club. He was a 1906 graduate of Jefferson Medical College, Philadelphia.

***Dr. Samuel E. Diamond**, Chicago, died Feb. 7 at the age of 65. He was on the staff of Cuneo and Columbus Hospitals.

***Dr. Edward F. Hess**, widely-known Chicago urologist, died Feb. 9 at the age of 78. He was on the medical staffs of Alexian Brothers, St. Elizabeth and Henrotin Hospitals in Chicago.

***Dr. Fidelius Knoepfler**, a Chicago roentgenologist and cardiologist, died Feb. 4 at Alexian Brothers Hospital, where he served on the medical staff for 40 years. He was also on the staff of Grant Hospital and was a founding member of the Alexian Brothers Hospital Foundation. Dr. Knoepfler was 78.

***Dr. Jefferson D. McCullough**, Aurora, died Feb. 9 at the age of 75. A practicing physician and surgeon for 43 years, he was associated with Aurora's three hospitals, Copley, St. Joseph Mercy and St. Charles.

Dr. George Bendell Rosengrant, Downers Grove, died Jan. 10 at the age of 68. He attended Hyde Park High School, Loyola University and the University of Chicago Medical School. He served in the U.S. Army during World War I and as a major in World War II. For 26 years he had been examining physician at Illinois Central Hospital, Chicago, and for the past 19 years he was examining physician at the Veterans Administration hospital.

* Member, Illinois State Medical Society.

University of Chicago Receives Fishbein Gift

The University of Chicago recently announced a gift of \$230,000 from Mrs. Morris Fishbein to help establish a professorship in the history of Biology and Medicine in honor of her husband, Dr. Morris Fishbein, a prominent physician and medical author.

The chair will be in the Department of History at the University.

Dr. Fishbein received his B.S. degree from The University of Chicago in 1910, and his M.D. degree from Rush Medical College in 1912. He is Emeritus Professor in the School of Medicine of The University of Chicago.

Additional gifts to help establish the professorship are being sought elsewhere.

The University of Chicago is conducting

a campaign to raise \$160,000,000 in three years, the largest goal ever set by an American university for such a period.

Mrs. Fishbein, in making the gift to the University, said:

"I have long believed that the physician, because of the increasing demands on his time for specialization in his particular area of medicine, has not been able to obtain a broad understanding of the various forces that interrelate so closely with his medical specialty.

"An understanding of the historical and cultural forces that interrelate with medicine, I believe, will enable the physician to acquire a deeper perspective of his role in society."

Government Sets Regulations for Laboratory Services

Final regulations setting the conditions for coverage of services of independent laboratories under the Medicare program have been published in the *Federal Register*, according to an announcement by Social Security Commissioner Robert M. Ball.

The regulations reflect extensive consultation with representatives of organizations and other experts in fields related to clinical laboratory service and medicare, Mr. Ball noted. They also take account of comments received from interested individuals and organizations in the 30-day period following publication of proposed standards last June 22, he added.

The attached listing includes the major changes.

1. The definition of "independent laboratories" excludes the offices of physicians, such as radiologists and cardiologists, whose primary practice, although conducted partly through diagnostic procedures, is directly attending patients or providing consultation. These services are covered as physicians' services under the program rather than as independent laboratory services.
2. The regulations provide for proficiency testing for all laboratories whose services are covered under the medicare program.
For laboratories with directors at the doctoral level, proficiency testing is required where the State provides the testing program.
For laboratories with directors below the doctoral level, proficiency testing is mandatory but may be provided by a State-approved privately operated program.
3. For laboratory personnel who have a designated amount of pertinent and recent clinical laboratory experience, a number of temporary exceptions are provided to the basic qualification requirements. These temporary exceptions extend only until July 1, 1971.

- a. Laboratories headed by directors who do not meet the doctoral degree requirement but have had at least one year of recent experience in directing a laboratory may qualify until July 1, 1971, if the director has a bachelor's or master's degree and certain experience, or he successfully completes a Public Health Service-

sponsored examination.

- b. Technicians and technologists must have had, respectively, five or 10 years of pertinent clinical laboratory experience, if they do not meet the basic experience and education requirements. There is also provision for substitution of education for experience in these requirements for technical personnel.
4. Provision is made for temporary approval through July 31, 1967, of a laboratory which otherwise meets requirements, where the State has not yet made proficiency testing available and also where a director with less than a bachelor's degree has indicated in writing his intention to take the Public Health Service examination.

Guide to Quality Patient Care Issued

A new tool for evaluating the care given to patients in short-term general or specialty hospitals has just been issued by the National League for Nursing, New York. Entitled "Quest for Quality: A Self Evaluation Guide to Patient Care," the publication may be used as a self-regulatory device by individuals on the health care team, as a medium of communication among team members, or as a tangible gauge for evaluating policies, procedures, and practices in a general or specific nursing situation.

The five sections of the guide correspond to the progressive stages of care a patient may expect to receive in a hospital: realization of illness, patient appraisal, planned care, execution of care and restoration.



Evaluation is accomplished by means of questions about patient care practices, each question calling attention to a different qualitative aspect of care. Columns are provided on each page for recording whether the particular practice is generally followed, not followed, or is judged inappropriate. Reasons for following or not following the practice are also recorded in columns. A spiral binding and large pages (8½ x 11 inches) make the book easy to handle and to work with.

"Quest for Quality: A Self Evaluation Guide to Patient Care" was prepared by the committee on Quality of Patient Care of the NLN Department of Hospital Nursing, with assistance from consultants in patient care selected from many disciplines.

starts fast...
keeps going...
relieves pain...



effective pain relief within 15 minutes...lasts 6 hours or more

 PERCODAN relieves pain fast—usually within 15 minutes—and for prolonged periods, usually for 6 hours or more. Further, its speed and potency are *predictable* in the wide middle range of pain.  PERCODAN is well tolerated and rarely causes constipation. **Usual Adult Dose:** 1 tablet every 6 hours. **Precautions:** The habit-forming potentialities of Percodan are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although

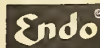
generally well tolerated, Percodan may cause nausea, emesis or constipation in some patients. Percodan should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. *Literature on request.*

PERCODAN[®]



Each scored yellow Percodan Tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 mg. oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine. U. S. Pats. 2,628,185 and 2,907,768

ENDO LABORATORIES INC., Garden City, New York



University of Illinois Accepts \$877,378 in Grants

The University of Illinois Medical Center Campus, Chicago, has accepted an overall total of \$877,378 in research and training grants for the period of Dec. 21, 1966, through Jan. 23, 1967.

Out of the 30 grants listed, 22 grants totalling \$691,958 were from the United States Public Health Service.

The funds were allocated as follows: \$596,998, College of Medicine; \$253,647, College of Dentistry; \$22,414, College of Pharmacy; and \$4,319, the College of Nursing.

The largest single grant \$167,579, was awarded to Dr. Samuel Pruzansky, professor of dentistry and associate director of the Cleft Palate Clinic and Training Program in the College of Dentistry, by the U. S. Public Health Service for studies on "Congenital Malformations of the Head."

The grants are listed below by college, project title, amount and granting agency, name and title of investigator.

Project Title	Amount & Granting Agency	Name and Title
COLLEGE OF DENTISTRY		
studies on congenital malformations of the head	\$167,579, Public Health Service	Dr. Samuel Pruzansky, professor of dentistry and associate director, Cleft Palate Clinic
impact of water fluoridation on dental practice	\$86,068, Public Health Service	Dr. Bruce L. Douglas, associate professor of oral diagnosis
COLLEGE OF MEDICINE		
analogues of pyrimidines	\$13,907, Public Health Service	Dr. Stephen B. Binkley, professor of biological chemistry
tRNA: its synthesis, maturation, structure, and function	\$30,000, National Science Foundation	Dr. Athol L. Cline, assistant professor of biological chemistry
chemistry and mechanism of action of potential anti-viral agents	\$24,263, Department of the Army, Office of the Surgeon General	Dr. Ralph H. Kathan, assistant professor of biological chemistry

(Continued on page 378)



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1. Bradley, J. E., *et al.*: J. Pediat. 38:41 (Jan.) 1951.
2. Bradley, J. E.: Mod. Med. 20:71 (Oct. 15) 1952.
3. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.



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(Continued from page 376)

research career development—metabolism of plasma glycoproteins	\$14,344, Public Health Service	Dr. Janos Molnar, assistant professor of biological chemistry	preparation of a manual of viruses and non bacterial agents causing respiratory illnesses in man	\$5,836, Department of the Army, Office of the Surgeon General	Dr. Jackson
the surface chemistry of bone, dentin, and enamel	\$25,963, Public Health Service	Dr. Joseph Samachson, assistant professor of biological chemistry	laboratory and clinical investigation of hetacillin-dicloxacin mixture	\$9,148, Bristol Laboratories	Dr. Jackson
repeated infections and progress of chronic bronchitis	\$65,688, Public Health Service	Dr. Harry F. Dowling, professor and head of the Department of Medicine	career development award	\$829, Public Health Service	Dr. Georgiana Jagiello, assistant professor of medicine
studies of various anti-aldosterone agents	\$7,000, Merck Sharp & Dohme	Dr. Clarence L. Gantt, assistant professor of medicine	evaluation of fiogestic and HS-592	\$6,260, Sandoz Pharmaceuticals	Dr. Max Samter, professor of medicine
prevention of hepatitis after cardiovascular surgery	\$45,711, Public Health Service	Dr. Edsel K. Hudson, assistant professor of medicine	traineeship grant in occupational therapy	\$8,348, Public Health Service	Miss Beatrice D. Wade, associate professor and head of the department of occupational therapy
transmission of the common cold to volunteers under controlled conditions	\$57,380, Department of the Army, Office of the Surgeon General	Dr. George G. Jackson, professor of medicine	clinical nystagmography	\$3,241, Public Health Service	Dr. Nicholas Torok, associate professor of otolaryngology

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carbohydrate metabolism in erythrocytes of newborns	\$26,178, Public Health Service	Dr. Marvin Cornblath, professor of pediatrics
hemorrhagic disease in infants and children	\$33,861, Public Health Service	Dr. Irving Schulman, professor and head of the department of pediatrics
metabolic fate of neuropharmacological agents	\$33,742, Public Health Service	Dr. Everett W. Maynert, professor of pharmacology
metabolic fate of neuropharmacological agents	\$1,241, Public Health Service	Dr. Maynert
metabolism of aliphatic alcohols	\$25,140, Public Health Service	Dr. Martin P. Schulman, professor of pharmacology
digitalis on adrenal cortical hormone formation	\$17,152, Public Health Service	Dr. Klaus R. Unna, professor and head of the department of pharmacology
the epidemiology of cerebrovascular disease	\$42,168, Public Health Service	Dr. Adrian M. Ostfeld, professor and head of the department of preventive medicine and community health
an inhibitory agent in autonomic tissues	\$14,807, Public Health Service	Dr. Ruven Greenberg, associate professor of physiology
career development award	\$12,370, Public Health Service	Dr. M. Rue Bucher, associate professor of psychiatry
continuing medical education project	\$45,533, Department of Health, Education, and Welfare Public Health Service	Dr. George E. Miller, Director of the Office of Research in Medical Education
lung cancer preoperative radiation therapy study	\$26,888, Public Health Service	Dr. Robert J. Jensik, clinical professor of surgery

COLLEGE OF NURSING

professional nurse traineeship program—long term academic	\$4,319, Public Health Service	Dr. Mary K. Mullane, dean of the college
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COLLEGE OF PHARMACY

analytical studies of air pollution	\$22,414, Public Health Service	Dr. Cecilio L. Gracias, assistant professor of chemistry
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State PKU Testing Program Pays for Itself: Yoder

An Illinois PKU testing program, aimed at discovering potentially retarded children, has paid for itself many times over, according to State Public Health Director Dr. Franklin D. Yoder.

By a conservative estimate, it costs the state \$100,000 to maintain a retarded child in an institution for his lifetime, Dr. Yoder said. By discovering potential retarded children at birth and preventing retardation, the state saves the expense of their institutionalization.

"While the values of saving children from mental retardation are beyond all measure, the monetary savings to taxpayers when such children are spared lifetime institutional care can be estimated in dollars and are substantial," Dr. Yoder pointed out.

An Illinois law passed in 1965 made compulsory the testing of all newborns in the state for PKU. Comprehensive screening started in May of this year. Prior to that time, the department had initiated and sponsored screening programs in many hospitals and started extensive educational and service programs.

During the three years the testing has been carried on in the state, 14 of 300,000 newborn infants were found to have phenylketonuria (PKU), a metabolic defect that allows excess quantities of an amino acid to build up in the blood. If the infant is not placed on a restricted diet, the defect can result in severe, irreversible mental retardation, Dr. Yoder said.

The dietary product (Lofenalac) is currently being provided by the department to 70 diagnosed cases of PKU. The children range in age up to seven years and some have been receiving the dietary supplement for years. Consultation services also are being provided to physicians and families of all diagnosed cases, as well as to cases in which the laboratory findings are doubtful or borderline.

Under the program, 135 Illinois hospitals now send the infant blood samples to health department laboratories. Another hundred are certified to conduct their own analysis of the tests or use accredited private laboratories. Further tests can confirm the diagnosis.

The program has found the PKU rate in Illinois to be much lower than predicted by the U. S. Children's Bureau.

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NEW PHARMACEUTICAL SPECIALTIES

by Paul deHaen

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Combination Products—Consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

NEW SINGLE CHEMICALS

SYMMETREL Antiviral Rx

Manufacture: E. I. du Pont de Nemours

Nonproprietary Name: Amantadine HCl

Indications: Prophylaxis of respiratory infections caused by influenza A₂ (Asian) virus strains.

Contraindications: Not to be used in patients with established A₂ influenza or other respiratory illness.

Dosage: Adults—200 mg. daily.

Children—(1 to 9 years) 2 to 4 mg./lb./day not to exceed 150 mg. (9 to 12 years) 100 mg. twice a day.

Supplied: Capsules—100 mg.; bottles of 100.

Syrup—50 mg./5 cc.; one pint bottles.

DUPLICATE SINGLE PRODUCTS

KLORT Ataraxic and tranquilizer Rx

Manufacturer: Lemmon Pharmacal Co.

Nonproprietary Name: Meprobamate

Indications: Management of anxiety or tension.

Contraindications: In cases where idiosyncrasy or hypersensitivity to meprobamate exists.

Dosage: 400 mg., 3 or 4 times daily.

Supplied: Tablets—400 mg.; bottles of 100 and 1000.

DUPLICATE SINGLE PRODUCTS

PROTRAN Ataraxic and tranquilizer Rx

Manufacturer: Carrtone Laboratories

Nonproprietary Name: Meprobamate

Indications: Management of anxiety or tension.

Contraindications: In cases where idiosyncrasy or hypersensitivity to meprobamate exists.

Dosage: 400 mg., 3 or 4 times daily.

Supplied: Tablets—400 mg.; bottles of 100 and 1000.

COMBINATION PRODUCTS

RHINSPEC Cold Preparation—General o-t-c

Manufacturer: Lemmon Pharmacal Co.

Composition:

Acetaminophen	300 mg.
Glyceryl guaiacolate	100 mg.
Phenylephrine HCl	5 mg.

(Continued on page 383)

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SPECIALTY REVIEW COURSE IN MEDICINE, Part II, June 5
SPECIALTY REVIEW COURSE IN ORTHOPEDICS, April 10
PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates

ESSENTIALS OF PLASTIC SURGERY, One Week, April 3

PROCTOSCOPY & VARICOSE VEINS, One Week, May 8

THORACIC SURGERY, One Week, April 3

UROLOGY, One Week, April 10

ADVANCES IN SURGERY, One Week, May 1

GENERAL SURGERY, One Week, April 3 and May 1

OBSTETRICS, General & Surgical, One Week, April 10

GYNECOLOGY, Office & Operative, One Week, April 3

VAGINAL APPROACH TO PELVIC SURGERY, One Week, April 24

GENERAL PRACTICE REVIEW, One Week, April 3

DIAGNOSTIC RADIOLOGY, One Week, April 10

FLUIDS & ELECTROLYTES, One Week, April 17

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Information concerning numerous other continuation courses available upon request.

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GENERAL SURGEON, Internist, Family Physician (Generalist) Interested in satisfying practice with time for home life. Long established mixed Generalist and Specialist group in Greater Kansas City area. Rapidly growing community, excellent hospital facilities. Salary one year, then partnership. Roytown Clinic, 9406 E. 63rd St., Roytown 33, Missouri.

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OPENING FOR PSYCHIATRIST, SURGEON AND GENERAL PRACTITIONER. (Psychiatric or geriatric experience desirable but not essential.) 1680-bed general medical-surgical and psychiatric hospital with excellent facilities and progressive staff, on equal opportunity employer. Salary \$12,873.00 through \$23,013.00 according to training and experience. Write to Director, VAH, Danville, Illinois.

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MODERN—MEDICAL—Dental Bldg. Office available March 1, 1967 Nine rooms. 900 sq. ft. Pediatrician present occupant. Parking, air conditioning; near downtown. Write Dr. T. Wise, 307 West University, Champaign, Illinois.

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Pharmaceutical Specialties

(Continued from page 381)

Indications: To facilitate productive cough and to relieve nasal congestion and aches and pain associated with the common cold.

Contraindications: Not for children under 3 years of age; persons with hypertension, heart disease, diabetes, thyroid disease, or high fever and persistent cough should use it only as directed by physician.

Dosage:

Adults—1 or 2 tablets 3 or 4 times daily
Children, 6 to 12 years—1 tablet 3 or 4 times daily; 3 to 6 years— $\frac{1}{2}$ tablet 3 or 4 times daily

Supplied: In bottles of 100 and 1000 tablets.

COMBINATION PRODUCTS

PORTAGEN Nutrient o-t-c

Manufacturer: Mead Johnson

Composition: Medium chain triglycerides

Indications: For persons who have difficulty in absorbing conventional fats.

Dosage: Not stated.

Supplied: Powder, unflavored—in 1 pound cans.

2/G Cough Preparation o-t-c

Manufacturer: Pitman-Moore

Composition: Each 5 cc. contains:

Clyceryl guaiacolate	100.0 mg.
Chloroform	13.5 mg.
Alcohol	5 %

Indications: Symptomatic treatment of respiratory conditions associated with cough and the presence of thick tenacious exudate in the lower

respiratory tract.

Dosage: Adults—1 tsp. every 3 to 4 hours, as necessary.

Children, 6 to 12 years—one-half of the adult dose.

Supplied: In 4 oz. bottles.

NEW DOSAGE FORMS

ATARAX Ataraxic and tranquilizer Rx

Manufacturer: J. B. Roerig & Co.

Nonproprietary Name: Hydroxyzine HCl

Indications: Anxiety and tension of various origins; as an adjunct to treatment of alcoholism; allergic conditions with strong emotional overlay.

Contraindications: Not for subcutaneous or intraarterial injection; in patients with hypersensitivity to it; in early pregnancy.

Dosage: Adults—i.m. or i.v.—25 to 100 mg. singly or every 4 to 6 hours depending on condition.

Children—i.m.—0.5 mg./lb. body weight.

Supplied: Disposable syringes—25 mg./cc.; 50 mg./cc.; 100 mg./2 cc.

VALIUM Ataraxic and tranquilizer Rx

Manufacturer: Roche Laboratories

Nonproprietary Name: Diazepam

Indications: Tension and anxiety states, adjunct to treatment of alcoholism, prior to minor surgical procedures, to alleviate muscle spasm associated with cerebral palsy and athetosis.

Contraindications: Infants, patients with a history of convulsive disorders or glaucoma, patients with a known hypersensitivity to diazepam.

Dosage: i.m. or i.v.—2 to 10 mg., every 3 to 4 hours. Not more than 30 mg. should be given within an 8-hour period.

Supplied: Ampuls—10 mg./2 cc.; in boxes of 10.

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Abstracts of Board Actions

Meeting of March 11-12, 1967

DR. RALPH N. REDMOND RESIGNS

Dr. Arthur F. Goodyear, Chairman of the Illinois State Medical Society Board of Trustees, has informed the board that Ralph N. Redmond, M.D., Sterling, has resigned as trustee of the Second District because of ill health. His unexpired term will be filled at the regular trustee elections conducted by the 1967 House of Delegates. Dr. Goodyear appointed Mather Pfeiffenberger, M.D., trustee of the Sixth District, to replace Dr. Redmond on the Finance Committee.

NEGOTIATIONS WITH DIVISION OF VOCATIONAL REHABILITATION

The Board has authorized the Committee on Usual and Customary Fees to attempt to negotiate with the Illinois Division of Vocational Rehabilitation on revision of a fee schedule developed by the division in cooperation with a "statewide medical advisory committee of practicing physicians." The Illinois State Medical Society has taken the position that this group of physicians had no authority to negotiate any fee plan for ISMS and this method of approach does not meet with the approval of the ISMS Committee on Usual and Customary Fees, the only authorized agency for the society. It is claimed that the fee schedule, which went into effect March 1, increases payments to physicians by 37 percent and will provide a large majority of them with their usual fees.

BLUE SHIELD CONTRACT WITH STEEL WORKERS

The House of Delegates will be asked to decide if the Illinois State Medical Society should agree to accept the usual and customary fees as full payment from Blue Shield under a contract to provide medical-surgical coverage for the United Steel Workers of America. The Board of Trustees has approved this in principle as an interim measure for planning purposes, but has referred the question to the House for final action.

ANNUAL BANQUET SCHEDULED

The Annual Illinois State Medical Society banquet will be held Tuesday, May 23, during the society's convention at the Sherman House. The format will be a dinner dance.

NO ANNUAL DUES INCREASE CONTEMPLATED

The Finance Committee has informed the Board of Trustees that the projected 1968 budget of the society is balanced and no annual dues increase is contemplated. The budget will be presented in detail to the House of Delegates Reference Committee on Finances and Budgets.

AGREEMENTS WITH PUBLIC AID DEPARTMENT

Two recommendations of the Medical Advisory Committee to the Illinois Department of Public Aid have been approved by the Board of Trustees: (1) Support of action to allow physicians to bill the Public Aid Department directly for care of patients covered by Title XIX of Medicare, and (2) To allow the Department of Public Aid to deal with a single committee of each county medical society on all aspects of Medicare such as fees, utilization, quality of care, etc.

RADIATION COMMITTEE RECOMMENDATIONS APPROVED

The ISMS Board of Trustees has approved the following recommendations of the Committee on Radiation:

(1) Required periodic leak testing of all sources containing radio-active elements to be the responsibility of the owner in all cases; (2) Fixed lead 2-10 in a controlled area should be disregarded; (3) Permit the free use of radium if the patient is in a private room and if the source is employed in accordance with accepted therapeutic techniques; (4) Until such time as substitutes for radium are fully proven equal or superior, the use of radium should be facilitated, and (5) the Illinois Department of Public Health should establish a review committee composed of two radiologists, one diagnostic radiologist, one hospital radiation physicist, one specialist in nuclear medicine and one dentist to consider problems that arise with the use of ionizing irradiations in medicine.

DIPLOMA NURSING SCHOOLS SUPPORTED

The Board of Trustees has endorsed the following recommendation of the Committee on Nursing: "The diploma school of nursing plays an important role in providing nurses for the bedside care of patients, and should be encouraged to continue to fulfill this role as long as there is a need for this type of nursing care."

SESQUICENTENNIAL COMMITTEE TO BE APPOINTED

The Board has approved appointment of a committee of approximately 150 ISMS members to work with the Sesquicentennial Commission of Illinois planning the state's 1968 celebration.

RECOMMEND ESTABLISHING COUNCILS

Dr. Andrew Brislen, chairman of the Committee on Constitution and Bylaws, has described for the Board of Trustees a proposed reorganization of the society into a series of councils under which committees would operate. The plan is being developed in accordance with the 1966 House of Delegates order to increase efficiency of the society's committee system. It was pointed out that further study of the plan, in cooperation with the Committee to Study Committees, is necessary before the plan can be presented for House approval.



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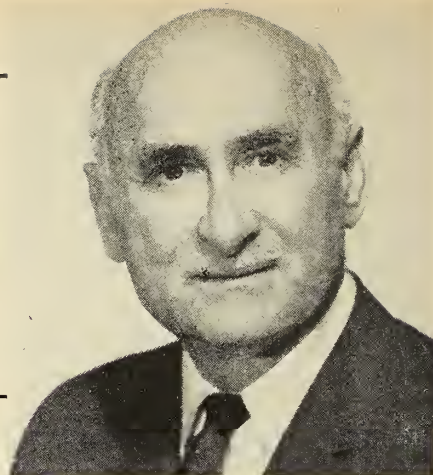
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The president's page



Caesar Portes, M.D.

Medical Quackery

Today, quackery is a big business. According to the Food and Drug Administration, "At least one billion dollars a year is spent on falsely promoted worthless or dangerous products. Over five million dollars is wasted on unnecessary or falsely represented vitamin products and so-called health foods. Older people, especially, are likely to be victimized by quackery. Chronic diseases like arthritis, provide the richest market for quack treatment and products. A national survey has shown that arthritic patients are spending 250 million dollars a year on misrepresented remedies."

However, it isn't only the money that is spent needlessly about which we are concerned. We are concerned about the danger to the health of the public caused by quackery because of prolonged and useless treatment. Also because it prevents the victim of the quack from coming to the doctor in time when a cure or control could be accomplished. However, it isn't only the fault of the quack, it is also the fault of the public. The reason for the existence of these quacks is the fact that most of us are alike, we are all human beings and we like to take the path of least resistance. For example, the woman with the lump in her breast, who has been told by her doctor to have it removed surgically. The woman refuses to listen to her doctor because she doesn't like hospitals, she doesn't want surgery, she hates anesthesia, she doesn't like the pain associated with this

type of treatment. However, she heard about some fellow down the road several miles who's selling some miracle pills, who promises her that if she swallowed these pills it would melt the tumor away. You see, that's easy. So she falls for that; and then three or six months later when she does come to see her doctor again, it is too late. Another example would be of a person who sees bleeding from the rectum, who blames it upon "piles" and who has also been told he ought to be examined with a proctoscope, and x-rays, stool examinations. Again, he refuses, because this is too tedious and perhaps a little bit uncomfortable. It is much easier to go to one of these places that advertise cures for rectal bleeding by means of high colonic irrigations and ointments and suppositories. So he too falls for this mode of treatment and then when he comes back to the doctor again there is a blooming carcinoma of the rectum or recto-sigmoid. The same goes for these poor people who are suffering with diabetes or arthritis or many other diseases. We must preach to the public that they must not succumb to these nostrum peddlers. That these quacks are only interested in their pocket-book, not in their welfare.

We must make the public understand that they should consult their family physician, a man in whom they have utmost

(Continued on page 587)

Congestive Heart Failure and Complete Heart Block:

Treatment with a Permanent Transvenous Catheter Pacemaker

By GEORGE KROLL, M.D., JOAN ORLANDO, M.D.,
AND FIDEL MACALALAD, M.D. / CHICAGO

Intracardiac pacing from an intravenous indwelling electrode first reported in 1959,¹ has been used to [1] temporarily pace the heart to prevent or treat Stokes Adams attacks, [2] increase cardiac output and improve myocardial, renal and cerebral function, [3] during general surgical procedures in patients with heart block and [4] to control the heart rate during anesthesia and thoracotomy procedures for implantation of electrodes in the ventricular myocardium.

The purpose of the following case report is to present the successful treatment of a patient with intractable heart failure and complete heart block with a permanent transvenous pacemaker and to outline the technics in the proper use of the therapy.

Report of A Case

A 70-year-old retired policeman was admitted to the hospital on Dec. 13, 1965, because of persistent congestive heart failure refractory to treatment with digitalis, diuretics, salt restriction and anticoagulants. He first developed exertional dyspnea and mild angina pectoris in 1955 following a syncopal episode. Complete heart block was documented in 1957 during hospitalization for excision of renal cysts.

In 1960 he experienced a myocardial infarction and several weeks later was re-

hospitalized for the treatment of frank congestive heart failure. Idioventricular rhythm with rate of 38 per minute and a diastolic blowing decrescendo murmur at the aortic area and left sternal margin were present. During the subsequent years he maintained periods of borderline compensation alternating with frank decompensation. Several weeks prior to admission persistent orthopnea, nocturnal dyspnea, severe exertional dyspnea, anorexia and weakness developed.

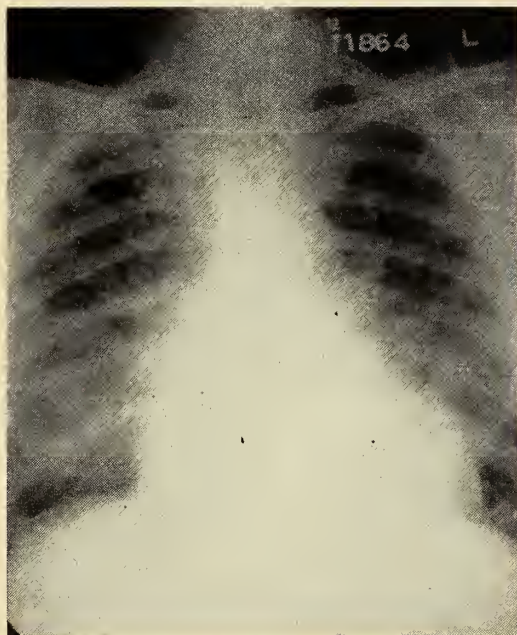


Fig. 1. X-ray [12/14/65] shows dilatation of the aorta with generalized cardiomegaly and prominent hilar and peripheral vascular lung markings.

On physical examination the patient was orthopneic in a semi-recumbent position of 45 degrees. Respirations were 26 per minute; pulse 33 per minute, regular, of the Corrigan type. The neck veins filled from

This report is from the medical and surgical services of the Veterans Administration Research Hospital and the departments of medicine and surgery, Northwestern University Medical School, Chicago. Dr. Kroll is director of the hospital's heart station and assistant professor of medicine at Northwestern, a Fellow of the American College of Physicians and the American College of Cardiology. Dr. Orlando is a fellow in cardiology and Dr. Macalalad is senior resident in surgery.

below and were distended. Blood pressure was 150/50 mm. Hg. in both arms. Coarse and crepitant rales were heard in both lower lung fields. The left heart border was 15

cm. from the mid-sternal line with a heaving apical impulse. There was a grade II/VI blowing holosystolic murmur at the apex and a grade II/VI short high frequency de-

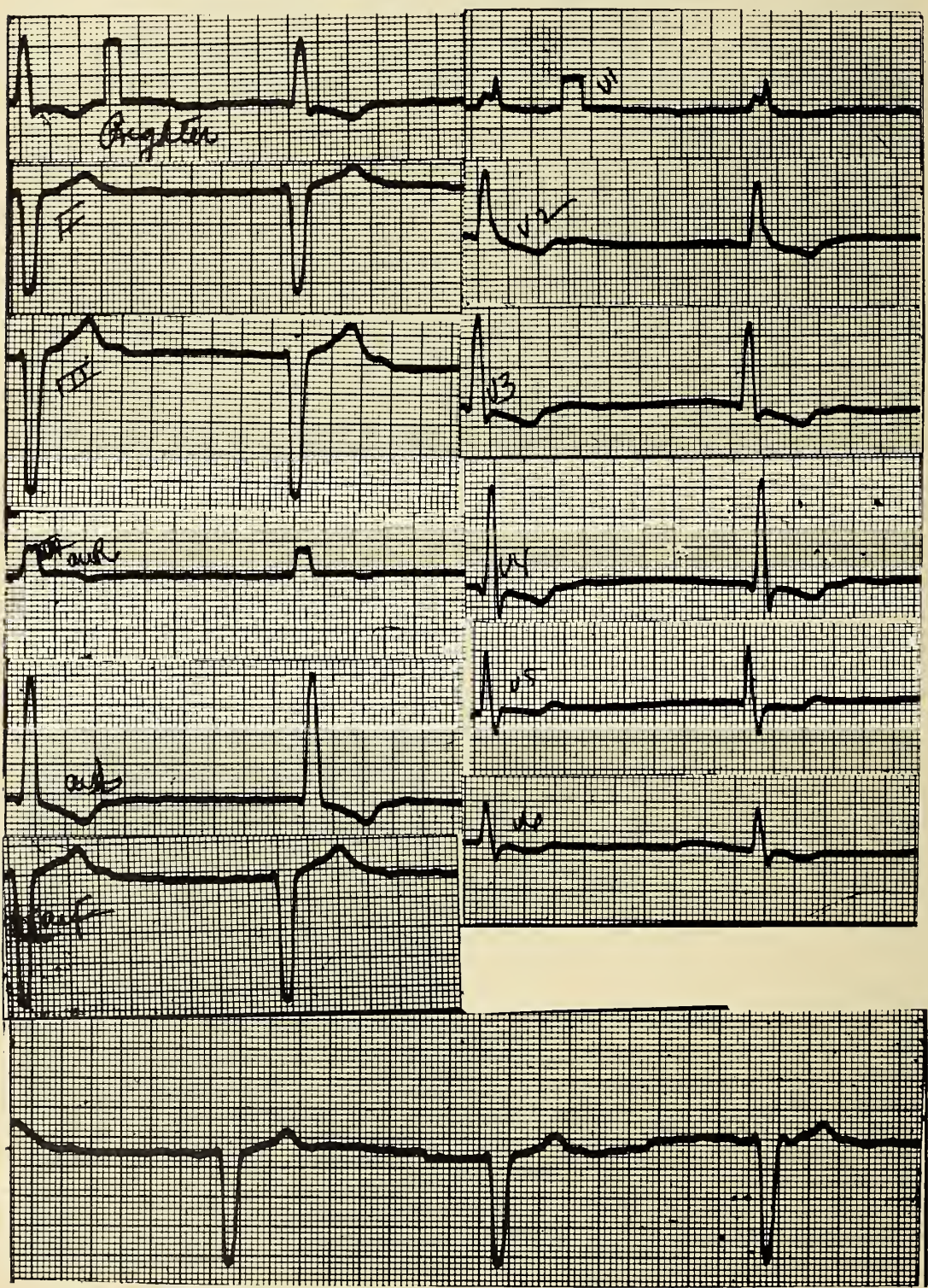


Fig. 2. reveals atrial fibrillation with complete heart block with slow idioventricular rhythm, rate 33 per minute, with digitalis effect.

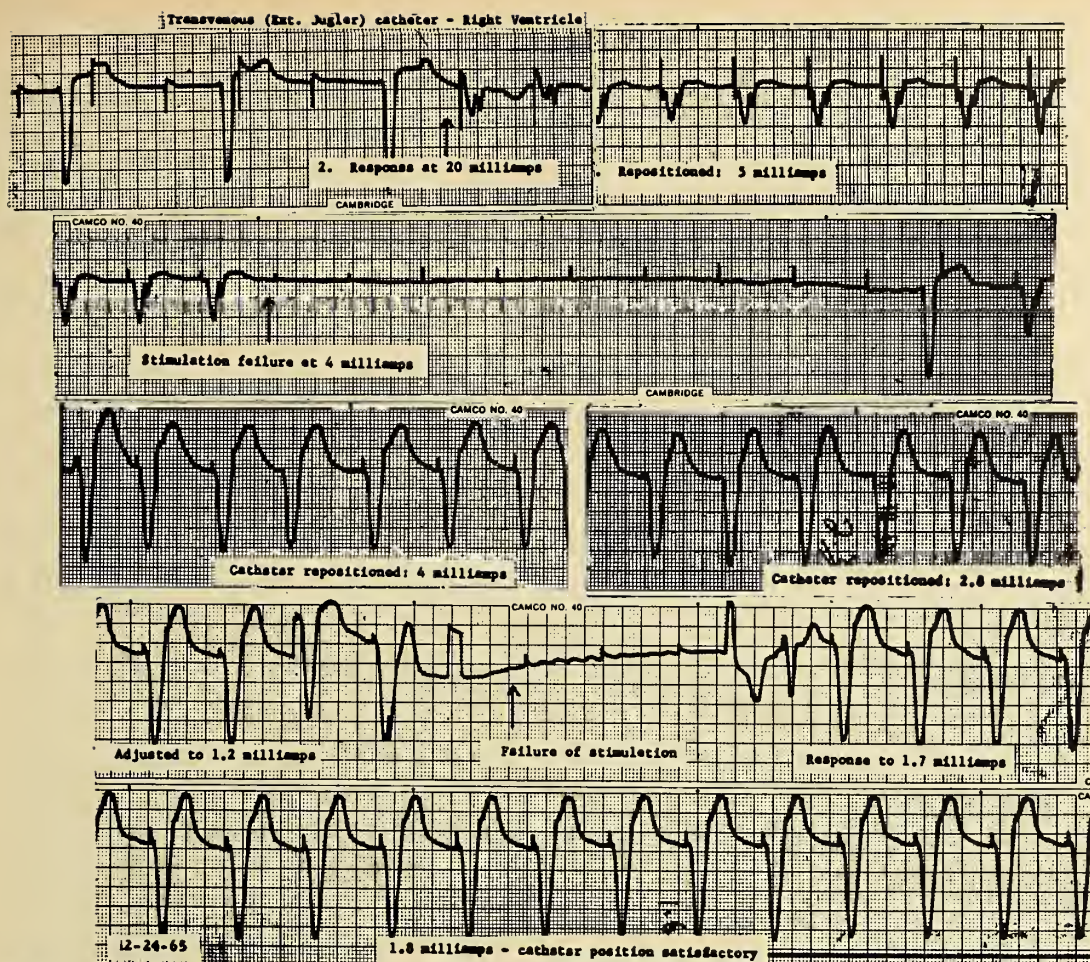


Fig. 3. reveals a composite of serial lead II electrocardiograph strips during positioning of the transvenous catheter in the right ventricle through the external jugular vein. The response of the ventricle to various milliamperages is demonstrated with final satisfactory ventricular capture at 1.8 milliamperes.

crescendo murmur at the right base and left sternal margin. The liver edge was palpated 5 cm. beneath the right costal margin. A trace of pretibial edema was present.

A complete blood count and urinalysis were normal. The blood urea nitrogen was 20 mg. per 100 ml.; fasting blood glucose 84 mg. per 100 ml.; serum sodium 139 mEq. per L.; potassium 4.0 mEq. per L.; chlorides 107 mEq. per L. and carbon dioxide content 20 mEq. per L. Serum oxalacetic glutamic transaminase determinations were 13, 12, 22 units and lactic acid dehydrogenase were 400, 450, 475 units respectively on successive days. The V.D.R.L. test was non-reactive. Serum proteins were normal. A chest x-ray [Fig. 1] revealed marked generalized cardiomegaly and hilar congestion. The electrocardiogram [Fig. 2] indicated atrial fibrillation with complete heart block and idioventricular rhythm with a rate of 33 per minute.

The patient was treated with bed rest, 500 mg. sodium diet, and diuretics including combinations of hydrochlorothiazide, spironalactone and intermittent mercurial injections. Digitalis was withheld and anticoagulants were continued. Multiple 15 mg. doses of sublingual isoproterenol were ineffective in increasing the ventricular rate. An infusion of isoproterenol at 5 micrograms per minute produced frequent multifocal ectopic ventricular systoles. Four days after admission in attempt to improve cardiac output, a temporary transvenous bipolar catheter pacemaker was placed, through the right median basilic vein, in the right ventricular outflow tract. Two days later the patient withdrew the catheter during an episode of nocturnal confusion. Despite a diuresis and weight loss of 16 pounds, anorexia, nocturnal confusion, dyspnea, and orthopnea persisted and angina reoccurred at rest. A permanent trans-

venous catheter pacemaker was inserted 10 days after admission.

Description of Procedure

The technique suggested by Chardack,² Siddons and Davis³ was adapted; a bipolar electrode was used. This is constructed of two spring coils made from an alloy of nickel and cobalt [Elgiloy] with stainless steel stylets terminating in platinum electrodes. A silastic flexible tubing encases the catheter except the platinum electrodes and terminals.* With local anesthesia and sterile technique under flourescopic image intensifier control, the catheter electrode was passed via the right external jugular

* Metronics Bipolar catheter electrode 5821 - c.

vein into the apex of the right ventricle. Proper position was ascertained by feeling its resistance against the apex and observing the position and motion of the catheter. Threshold responses were determined by connecting the terminals of the catheter with a conductor cable to a battery powered pacemaker. Ventricular capture to a stimulus of less than 2 milliamps was obtained after several attempts of repositioning the catheter. Both stylets were then withdrawn and stability of the threshold response to less than 2 milliamps was again determined. After final positioning of the catheter, pacing was discontinued temporarily as the catheter was tunneled

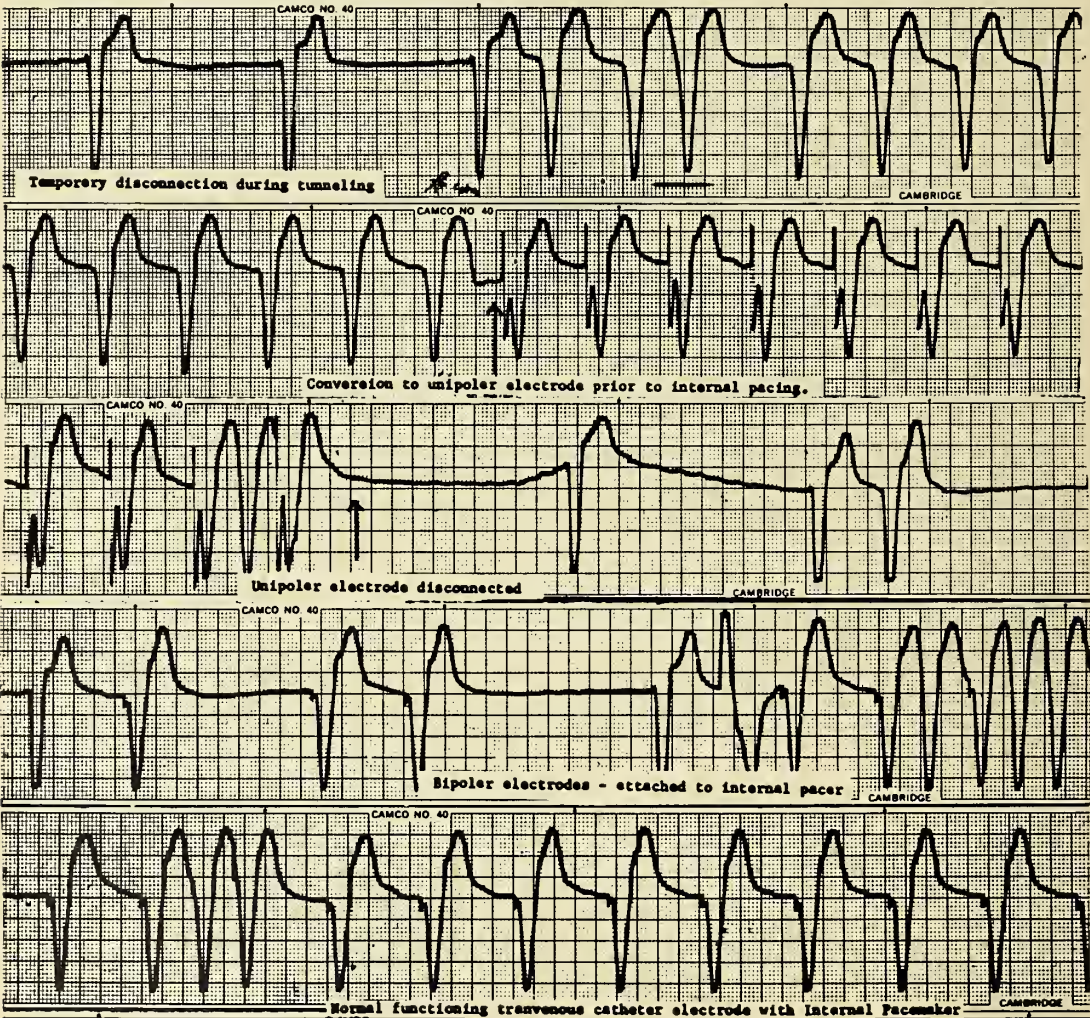


Fig. 4. Further serial electrocardiograph strips indicating ventricular responses after final positioning of the catheter. As bipolar electrode is disconnected during tunneling; note resumption of ideoventricular rhythm in Strip I. Third and fourth strips demonstrate the discontinuation of external unipolar lead pacing with resumption of bipolar pacing as the electrodes are attached to the internal pulse generator. A short period of ventricular instability occurs in strip 4 and 5 prior to stable ventricular capture with functioning parasystole from internal pacemaker.

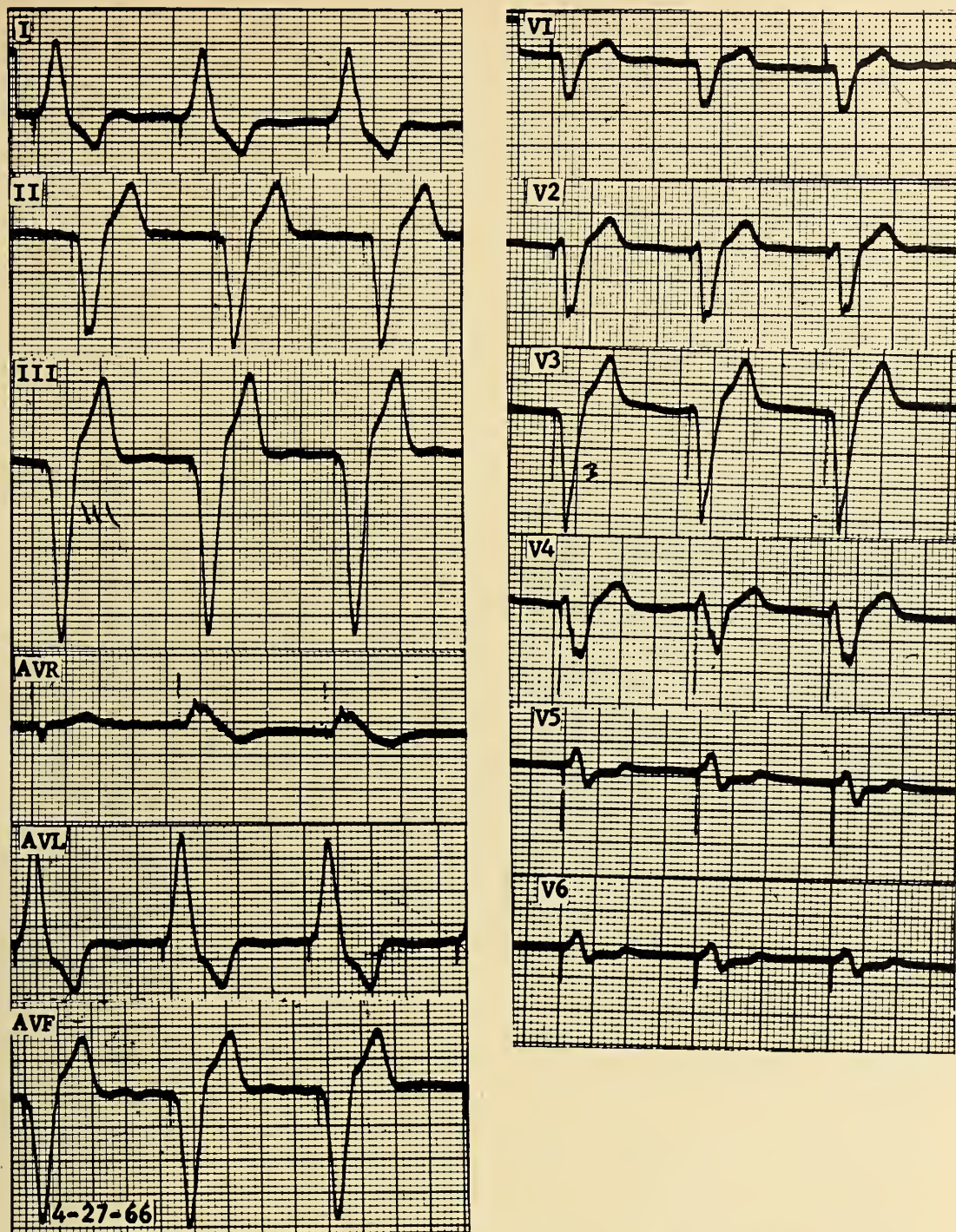


Fig. 5. Several months following pacemaker installation a normal functioning parasystole focus is present, rate 69 per minute from the right ventricular pacemaker. The chest leads are half standardized.

subcutaneously from the external jugular vein over the clavicle to the right infraclavicular fossa which was prepared for subcutaneous placement of the permanent pulse generator. Prior to final attachment, one lead of the bipolar electrode

was reconnected to the external pacer and unipolar stimulation continued. One terminal of the cable attached to the subcutaneous area served as an indifferent electrode. The free second lead terminal of the catheter was inserted into the permanent

pacemaker receptacle and appropriate adjustments made. Thereafter, the unipolar lead stimulated by the stand-by external pacer was disconnected and a functioning bipolar electrode made by inserting this lead terminal into the second receptacle of the implantable pacemaker.

Fig. 3 and 4 reveal electrocardiograms recorded during the forementioned maneuvers to attain correct positioning of the catheter and also during final attachment of the catheter to the permanent internal pacemaker. Further adjustments and sealing of these connections with silicon rubber completed the procedure. The pacemaker was then permanently placed in the subcutaneous tissue below the right clavicle. Fig. 5 indicates function of the pacemaker several months later.

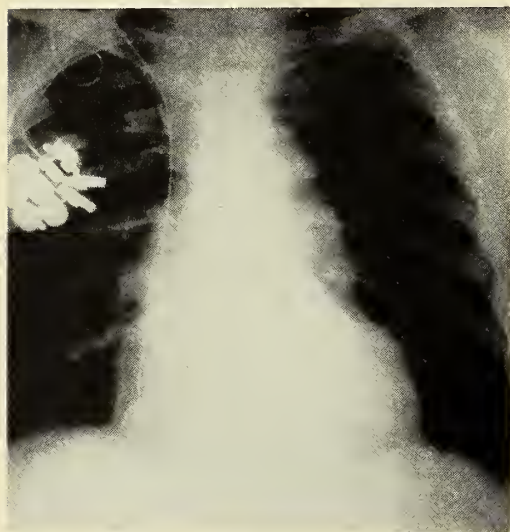


Fig. 6. Chest X-ray on 3/6/66. Pulse generator in place at right subclavicular pocket with transvenous catheter electrode tip at apex of right ventricle. There is a marked decrease in pulmonary congestion and diminution in cardiac size.

The patient's clinical condition progressively improved. All symptoms of congestive heart failure and angina disappeared during ambulation in hospital and did not recur during out patient follow-up of six months. There was also a marked improvement in mental functions and increased appetite. Seventeen days following discontinuation of digitoxin he was redigitalized with 2 mgm. of digoxin over a two-day period without further diuresis. The blood pressure remained 160/70 mm. Hg. and the diastolic murmur persisted. Fig. 6 indicates persistent decrease in heart size and hilar

congestion several months after permanent catheter placement.

The satisfactory response of refractory heart failure after increase in heart rate with electrical pacing is similar to that reported by others.⁴ However, the presence of aortic insufficiency, in addition to ischemic heart disease, may be a limiting factor in the degree of improvement. Persistent severe cardiomegaly reflects both conditions. The patient's improved mental status and increased exercise tolerance is consistent with an increase in cardiac output with improvement of coronary and cerebral flow. This is consonant with the recent hemodynamic studies of the effect of variation in ventricular rate in complete heart block.⁵

The placement of a permanent transvenous pacemaker offers the advantage of a minor surgical procedure under local anesthesia instead of a thoracotomy with the attendant risk and morbidity to a severely ill or elderly patient. However, the placement and proper positioning of the catheter requires skill and experience in cardiac catheterization. Since the output of the pulse generator is preset at 5 milliamps, the presence of a threshold response to less than 2 milliamps is highly desirable to insure continued normal pacemaker function. A high threshold is a contraindication for permanent placement of the catheter pacemaker. The procedure may be done without prior temporary transvenous pacing in the presence of a stable idioventricular rhythm. If the latter is required, a vein other than the right external jugular should be used, reserving this vein for the permanent catheter. The patient's heart rate and rhythm should be under constant observation with a cardiac monitor oscilloscope and instrumentation for immediate external pacing or electroconversion should be available. A set up for immediate infusions of isoproterenol, procainamide, or lidocaine should also be at hand.

Furman and Schwedel demonstrated the feasibility of long-term transvenous pacing using a unipolar catheter electrode.¹ Lagergren and his associates⁶ recently presented their results in 100 patients treated for periods up to 42 months with a permanent intravenous unipolar catheter. There was no immediate mortality. Eight of 10 patients over 80 years old survived up to three years. Of a total of 17 deaths, two were due to electrode displacement, and two

others were related to pacemaker failure. In addition, 27 electrodes required reinsertion; three because of infection, eight because of defective wire insulation, and 16 because of displacement. The high displacement rate may have resulted from use of freely movable external pacemakers in 75 percent of the patients.

Zucker et al.⁷ first reported the use of bipolar transvenous catheter pacemaker which functioned satisfactorily for two months, and indicated the bipolar electrode was superior to the unipolar one which requires larger voltage and a greater endocardial contact area. The course of 40 patients with a mean follow-up of 10 months has been presented by Chardack et al.^{2, 7} Two perforations and two coil fractures occurred in their early experience. No complications were reported in the last 31 patients in whom the stylets were completely withdrawn. There were two postoperative deaths: one from a mesenteric thrombosis followed thoracotomy for intramyocardial electrode implantation after initial coil fracture; the other was due to a myocardial infarction at nine days. Four additional deaths also occurred, one of which was due to congestive heart failure with the other three being non-cardiovascular. The remaining 34 patients are doing well. Kennedy,⁹ using similar techniques in 12 patients followed from two to 13 months, reported no operative mortality. Two cases of pacing failure required correction of the battery catheter contact. Two deaths occurred, one from congestive heart failure, and the other from progressive muscular dystrophy. Using a subclavian vein catheterization technique and an axillary power pack, Grace and his group had no immediate mortality in eight patients.¹⁰ Subsequently one patient required a thoracotomy for intramyocardial electrode pacing. Fatal ventricular fibrillation occurred in another patient.

Other major failures of the permanent bipolar transvenous pacemakers are right ventricular perforation, pacemaker induced ventricular tachycardia or fibrillation, and erosion of the pulse generator or catheter* through the skin in a small number of patients.^{11, 12} Thromboembolism has not been reported in spite of absence of use of anticoagulants. The electrode apparently be-

* The senior author has recently observed erosions of two catheters through the skin overlying the clavicle.

comes incorporated into the trabeculae and covered by a sheath of fibrous tissue thus preventing displacement and clot formation. The great majority of deaths has resulted from progression of the underlying cardiovascular disease and extra-cardiac factors.

These early reports compare favorably with the implanted cardiac pacemaker where the early operative mortality ranges between six¹³ and nine percent,² and total death rates of 18-27 percent.^{14, 15, 16} Nevertheless, the long-term stability of the plastic catheter, hazard of perforation or erosion, and potential failure from threshold alterations are still unknown. Therefore, the treatment of choice for symptomatic complete heart block in the low risk or young adult remains the intramyocardial electrode. Permanent transvenous pacing is the preferable procedure in the very aged or otherwise poor risk patient.

Summary

A 70-year-old patient with permanent complete heart block, aortic insufficiency, and congestive failure with severe angina pectoris who responded poorly to usual medical regimen improved greatly after placement of a permanent bipolar transvenous catheter pacemaker. The procedure is presented in detail with electrocardiograms illustrating pacemaker response. The safety and ease of installation with the later option of placement of myocardial electrodes, makes this the method of choice in any elderly or other high risk patient. It may also be utilized in patients with failure of previous intramyocardial electrode pacing.

Addendum

Grace, W. J. et al: Amer. J. Cardiol. 18: 886, 1966 reported further experiences with 29 patients treated with permanent transvenous pacemakers. Two patients expired in the hospital suddenly, one from ventricular fibrillation. Subsequently two patients required transthoracic epicardial pacemakers when transvenous units failed.

Additional reports of permanent transvenous catheter pacemakers were presented at the 16th Annual Scientific Session of the American College of Cardiology Feb. 15-19, 1967, Washington, D.C. Abstracts by Dack, S. et al; Goldstein, S., et al; and Shafer, R. B., et al; appear in the Amer. J. Cardiol. 19, Jan. 1967.

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(Continued on page 588)



IMJ

**SURGICAL
GRAND
ROUNDS**

Case Presentation:

Blastomycosis of Lung

Edited by JOHN M. BEAL, M.D.

Northwestern University Medical Center

Surgical Grand Rounds are held weekly at 8 a.m.; alternating between The Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentations from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of Surgical Grand Rounds held at Chicago Wesley Memorial Hospital on Oct. 15, 1966.

Dr. John Grimes: A 46-year-old white male funeral director had a chief complaint of chest pain of eight weeks' duration. The pain was on the right side and posterior. It was described as intermittent and sharp. The pain was worse when he coughed, took deep breaths or moved his right arm. He denied fever, chills, night sweats, weight loss, hemoptysis, or anorexia. Approximately six weeks before admission he had a chest x-ray at a mobile unit and was told that there was "a spot in his right lung." He was admitted to a hospital for two days and was treated with penicillin, but his symptoms did not change. He then entered Passavant Memorial Hospital on Sept. 5, 1966, for additional study. He continued to complain of pain in the chest. He had smoked three packs of cigarettes a day for many years and had a productive cough in the morning. He denied exposure to tuberculosis. Past history and review of systems was otherwise negative.

Physical examination was essentially negative with the exception that the liver was felt 4 cm. below the right costal margin. It was noted that he did not have palpable lymphadenopathy. Blood count and urinalysis were within normal limits. Roentgenograms of the chest were obtained.

Dr. Harold Matthies: A single film from a study about a week before he was admitted here demonstrates a large lesion in the right upper lobe. The study at Passavant shows a large shaggy mass in the right upper lobe and the lateral projection indicates that it occupies a posterior location. The most likely diagnosis is bronchogenic carcinoma (Fig. 1). This is likely in a patient who is a heavy smoker. However, the configuration of the bronchi in the upper lobe suggest the possibility that it is an inflammatory disease. This is supported by the laminograms which do not demonstrate the impression of a solid tumor mass, though questionable cavitation was present.

Dr. Grimes: The skin tests were negative except for the second strength PPD, which was markedly positive with 32 mm. of in-

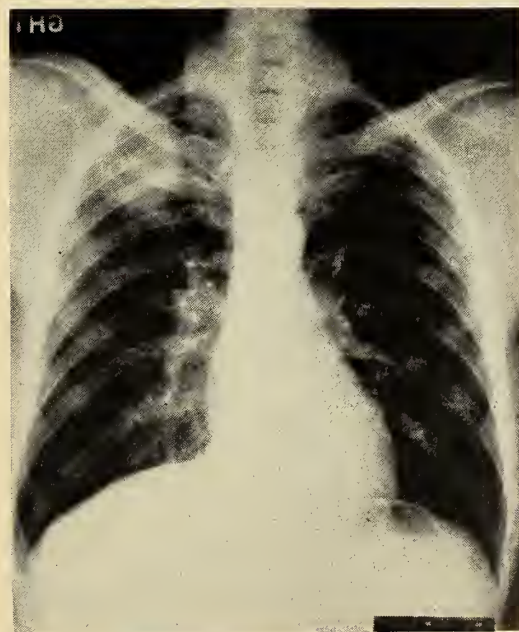


Fig. 1. Roentgenogram of chest demonstrated a large lesion in the right upper lung field.

duration. Multiple sputum samples were taken for acid culture and sensitivity and cytology. Acid-fast bacilli were not found and sputum cytology was normal. Pulmonary function was tested and was within normal limits. INH, streptomycin and neopacolate therapy was begun five days after admission. Further x-rays included a bone survey and an esophagogram; which were reported to be normal. A thoracotomy was performed 17 days later. One facet of the history was not obtained until after operation. The patient admitted that he is a golfer and plays golf three or four times a week. Rather than using the ball washer to clean his golf balls, he licks them. Dr. Shields will describe the operation during his discussion.

Dr. Thomas Shields: When the PPD skin test was performed, the patient developed a fever of 105° that same evening. Not only was the skin reaction marked but a slough occurred in the center of the skin test. This, combined with the x-ray characteristics of the lesion, led to consideration of a diagnosis of pulmonary tuberculosis although tubercle bacilli had not been identified by culture or by microscopic examination.

Dr. Shields: The other skin tests including one for blastomycosis were negative. The continued complaint of chest wall pain was a disturbing feature. We were also disturbed because we couldn't identify cavitation within the lesion by laminography. Because of the uncertainty of diagnosis, a short course of antituberculous medication was given before thoracotomy was undertaken. At the time of operation a firm indurated mass was found involving the posterior chest wall. The initial clinical diagnosis from gross examination was bronchogenic carcinoma with spread into the chest wall. Several pieces of tissue were submitted for frozen section and the pathologist reported only chronic inflammation. We elected to perform a right upper lobectomy and removed a portion of the posterolateral chest wall along with the lung.

Dr. Frank Carone: Sections of the lung show both an acute necrotizing inflammatory process with several abscesses and cavities and a chronic granulomatous response. The latter shows tubercle-like granulomas which contain round to oval fungal organ-

isms, approximately 10-15 microns in diameter with thick, double-contoured walls and occasional evidence of reproduction by budding. These findings are typical for *Blastomyces dermatitidis* (Figs. 2a and 2b).

Dr. Shields: Despite rather extensive resection of the chest wall, paradoxical motion of the area was not present, because this portion of the thorax is protected by the scapula.

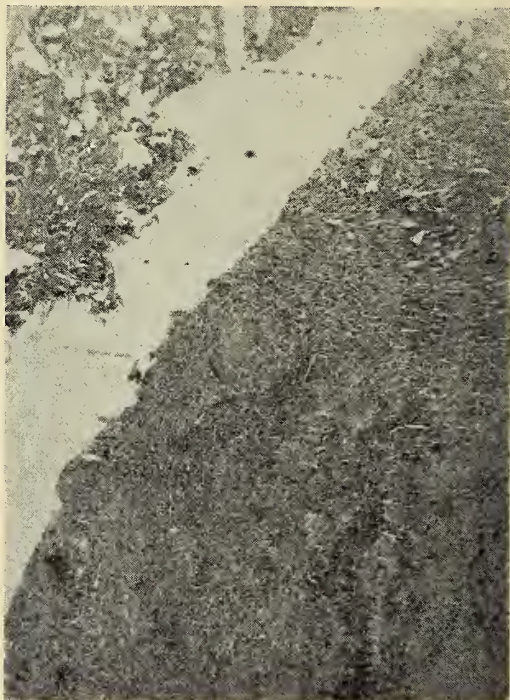


Fig. 2a. Low power microphotograph of section of lung demonstrates the inflammatory response which contains granulomas.

At least one medical textbook states that blastomycosis is common in Chicago. This is quite surprising to me, because there have been only six cases during the past 15 years at the Municipal Tuberculosis Sanatorium. In the literature there are few reports of patients who had been treated surgically and most of these have been operated upon with a mistaken diagnosis of bronchogenic carcinoma or pulmonary tuberculosis. Takaro in a review of surgery in fungal diseases (*) stated that the operative mortality was about 25 percent.

* Takaro, T.; Walkup, H. E. and Matthews, J. H.: The Place for Excisional Surgery in the Treatment of Pulmonary Mycotic Infections. *Dis. Chest.* 36: 19, 1959.

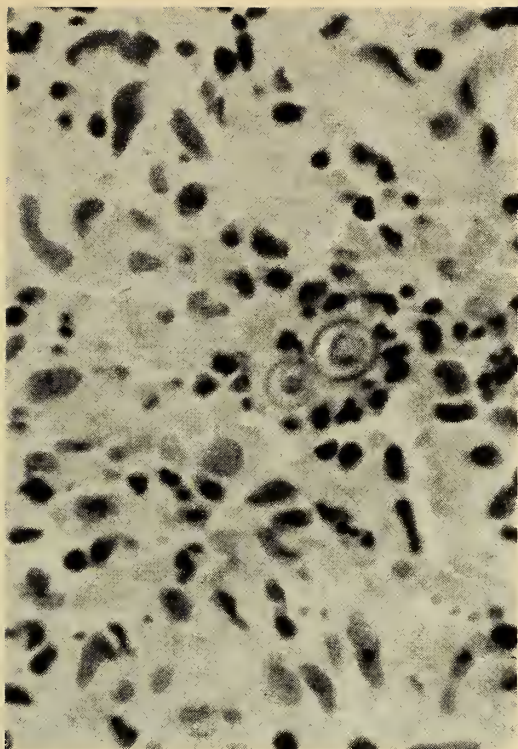


Fig. 2b. Higher magnification of section shown in Fig. 2a shows the organism, *Blastomyces dermatitidis*.

Eleven deaths occurred in 47 resections. Nine patients had recurrent or persistent disease postoperatively. The remaining 27 patients did well. However, most of these patients with blastomycosis did not have ancillary drug treatment. Dr. Kettel has consented to discuss the present therapeutic measures which are available for the medical treatment of blastomycosis.

Dr. Louis Kettel: North American blastomycosis presents a number of problems that are worthy of comment. The mycotic disease probably is more common than is usually thought. A few years ago the Veterans Administration reviewed retrospectively their experience with blastomycosis.¹ In the three Veterans Administration Hospitals in the Chicago area there were 20 patients in the 12-year period. Of the 198 patients in the series, 118 had pulmonary involvement. Sixty-nine of those with pulmonary disease also had skin involvement.

Chicago is identified with blastomycosis because some of the early investigations

were carried out at Rush Medical College and Cook County Hospital.² This resulted in the name, "Chicago Disease," although in the VA experience the incidence is greater in the south and southeastern parts of the country.

I would like to comment on this man's occupation and his "golf ball licking." Because blastomycosis commonly involves the skin, the organism was originally thought to become systemic through the skin. Today, most investigators consider that the lung is the site of entry. *Blastomyces dermatitidis* spores are inhaled and the skin becomes involved after systemic dissemination. Although *Blastomyces* has been found in some animals, the disease has not been known to spread from man to man or animal to man. In 1961, the organism was isolated from the soil for the first time. It is most likely that this patient's occupation was funeral director and his frequent excursions to the golf course exposed him to the wind and dust which at some time contained spores of the *Blastomyces dermatitidis* fungus. In the Veterans Administration study, more than 60 percent of the patients had dirt related occupations such as farming and construction work.

The blastomycin skin test was negative in this patient, but the complement fixation serology was 1:16 for the same antigen. At least 50 percent of patients with blastomycosis have either a negative skin test or a negative complement fixation titer. About one-third will have neither test positive. Before drug treatment with amphotericin B much was written about prognosis. In 1949, Smith³ noted that patients with a positive complement fixation titer and a negative skin test had a terrible prognosis. Smith further noted that those with neither positive skin test or serology, or both skin test and serology positive had a better prognosis; while patients with a positive skin test and negative serology had the best prognosis. In the Veterans Administration experience most patients were treated with drugs. Their results suggest that these serology and skin test findings are no longer prognostically useful. Why the serology may be positive and the skin test negative or why so many patients have no immune response at all, is unknown. The best explanation seems to be that the Blas-

tomyces antigen is inadequate.

Untreated systemic blastomycosis is nearly always fatal.⁴ Untreated disease localized in the lung has a variable prognosis tending to persist and cause increasing morbidity. Dissemination and progression of the disease from the lung are common. When treatment with amphotericin B is used one can expect 80 percent or better good initial results. Relapses tend to be frequent, however, and therapy has to be persistent. This patient is receiving amphotericin B. The drug causes chills and fever, nausea and vomiting, local irritation and phlebitis. A most important complication is renal damage. Both tubular and glomerular lesions have occurred. Calcium deposition and destruction of tubular cells are seen in kidneys examined after large amounts of amphotericin B have been given.⁵

The drug can be administered only intravenously in a pH 5 or greater buffered solution of 5 percent dextrose. Therapy is begun with low dosage—for example, 5 mg total. It is gradually increased to 1 mg/kg of body weight once daily. If increased blood urea nitrogen develops, the dosage is decreased or omitted for a day. Therapy is then restricted until a total dose of 1.5–2 grams are given, although some recom-

mend even higher doses. The duration of time taken to achieve this total dosage is apparently unimportant and medication given three times a week seems to be adequate. In this man, although he has had a successful pulmonary resection presumably for localized disease, the aim of therapy is to destroy any organisms that remain in hilar nodes or other unrecognized areas of the body. Close followup after completion of therapy is indicated. If pulmonary relapse occurs or evidence of dissemination develops, he should be retreated.

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Unprintable -

Suppose, at this stage, we were to ask a patient in the first few weeks of steroid therapy our question: "How good is the modern treatment of asthma?" His reply, coloured by the delights of the cortisone honeymoon, could well be in the modern idiom, "It's super." But if we were to put the same question a few months later, when his wheezing had returned bringing back his pills and atomizer in spite of his consumption of steroids, it could quite well be: "It's not so hot." And if one were unkind enough to put the same query some years later, when he now had a moon-shaped face, with acne worse than in his youth, a buffalo-humped silhouette, a rising blood pressure and had been told by his doctor, who patched up six broken ribs after he fell chasing Daisy into the cow bail, that he now had sugar in his urine, what would be his reply? If he were a Kiwi, it would definitely be unprintable.

Albert D. G. Blanc. *The New Zealand Med. Jl.* (Oct.) 1966



THE VIEW BOX



Fig. 1

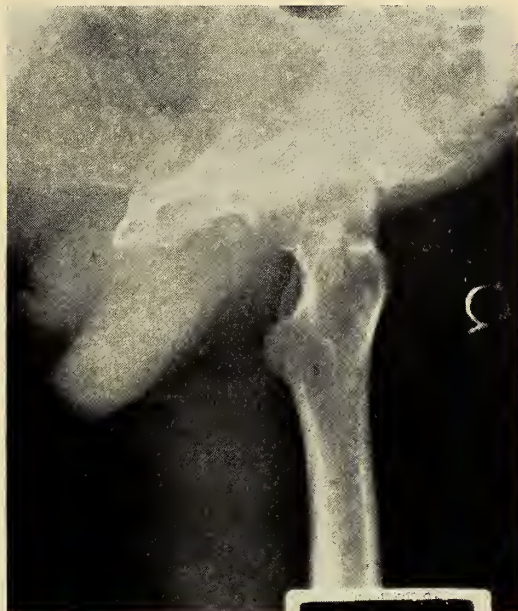


Fig. 2

BY LEON LOVE, M.D.

DIRECTOR, DEPARTMENT OF DIAGNOSTIC RADIOLOGY, COOK COUNTY HOSPITAL
AND ASSOCIATE PROFESSOR OF RADIOLOGY, CHICAGO MEDICAL SCHOOL

This 21 year old W/M entered the Orthopedic Clinic with a complaint of recurrent pain and stiffness in the left hip over a two-year period which had increased slightly in severity during that period. Skeletal survey, blood chemistry studies and physical examination showed no evidence of systemic disease.

Physical examination revealed the hip to be non-tender with only slight limitation of motion.

What's your diagnosis?

- 1) Tuberculous arthritis.
- 2) Synovioma.
- 3) Gout.
- 4) Rheumatoid arthritis.
- 5) Villonodular synovitis.

(Answers on page 588)

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

MDs Asked to Accept Usual Fee as Full Pay

Should Illinois physicians accept usual and customary fees as full payment from Blue Shield for service to steelworkers? That question—to be considered by the ISMS House of Delegates May 21-24—stems from National Blue Shield's desire to write the multi-million dollar, medical-surgical contract for the United Steelworkers. The contract would cover 75,000 persons in Illinois. To win it, Blue Shield needs the medical profession's cooperation in accepting the usual and customary fee payment concept. In return, Blue Shield will refer all fee disputes to county and state medical societies—and abide by their decisions. The proposed plan was accepted in principle by the ISMS Board of Trustees on March 11 and referred to the House of Delegates.

* * *

Medicare Certification Continues to Draw Fire

In addition to Blue Shield's proposal, the House will be asked at the ISMS annual meeting to consider several resolutions attacking Medicare's requirement that doctors certify a patient's needs for hospitalization. Resolutions already submitted ask that ISMS advise its members to refuse to sign special certification and recertification forms.

* * *

Seek Assistance for Incoming Physicians

Another resolution to be considered by the ISMS House of Delegates seeks establishment by the State Department of Registration and Education of a short-term license to be issued to physicians licensed in another state and who move to Illinois. Purpose is to allow such physicians—who would have to be graduates of a "Class A" U. S. medical school—to practice in this state pending issuance of their reciprocity license.

* * *

Workshop on Claim Forms On Annual Meeting Program

If you're puzzled by Medicare and Public Aid Claim forms, help is imminent. The ISMS Medical Economics Committee will sponsor a workshop on "Medicare-Public Aid Billing Problems" on May 22 at Chicago's Sherman House. Medicare Form SSA 1490 and Public Aid Form MS 132 will be discussed and the use of code numbers from *Current Procedural Terminology* will be explained. The code numbers are required on Public Aid Form MS 132. Questions will be welcomed. The workshop will begin at 9:00 a.m. in the Old Chicago Room and is open to all physicians and employees responsible for completing claim forms.

DVR Initiates New Payment Plan

A new "fee ceiling plan"—designed to increase physicians' fees between 25 and 60 percent—was put into effect March 1 by the Illinois Division of Vocational Rehabilitation. Purpose of the new plan is to accommodate the usual and customary fees of the "majority" of Illinois physicians, according to Dr. Emmet Pearson, DVR medical consultant. The ISMS Committee on Usual and Customary Fees is studying the plan.

* * *

Physicians Pleased With Public Aid Program

Reaction among Illinois physicians has been highly favorable toward the Public Aid Department's new policy of paying usual and customary fees. Ninety percent of county medical society officers responding to a questionnaire voiced their personal approval of the program—and indicated that their members felt the same. Their chief criticisms? Dissatisfaction with having to accept an assignment . . . an expected overload of paperwork . . . removal of local control and supervision. The new program was begun this year after months of negotiation between the ISMS Committee on Usual and Customary Fees and the Public Aid Department.

* * *

FDA Official Predicts Increase in New Drugs

New drugs approved by the Food and Drug Administration this year may double the number approved in 1966. Dr. Herbert L. Ley, Jr., director of the FDA's Bureau of Medicine, told the Chicago Medical Society's Clinical Conference that since the Federal Food, Drug and Cosmetic Act was amended in 1963, FDA has received between 160 and 200 new drug applications annually and has approved between 40 and 84 new drugs for marketing each year. This year, he said, new drug applications are being received at a rate twice as great as in 1966. "If the rate continues," he said, "the number received will equal levels of the late 1950's."

* * *

Health Insurance Source Book Available from ISMS

Are your "over 65" patients inquiring about private insurance to supplement their Medicare benefits? The Committee on Medical Economics has available a "Report on New Health Insurance Policies of Insurance Companies Available to Those Over 65", prepared by the Health Insurance Institute. The report lists names and addresses of the companies and provides a brief description of their policies. For a free copy, write the ISMS Division of Public Relations and Economics, 360 N. Michigan Ave., Chicago, 60601.

* * *

More ECF's Certified Under Medicare Law

The Committee on Aging published in the February issue of *Illinois Medical Journal* a list of Extended Care Facilities certified under Medicare. To keep the list current, add: Eunice C. Smith Home, Alton . . . Americana Nursing Center, Urbana . . . Broodwood Convalescent Center, Des Plaines . . . Dobson Plaza Nursing Home, Evanston . . . Presbyterian Home, Evanston . . . Clarytona Manor, Lewistown . . . Burnside Nursing Home, Marshall . . . Evenglow Lodge, Pontiac . . . St. Ann's Home & Infirmary, Techny.

—BY GAYLEN LAIR AND MARVIN SCHRODER

Abortion Symposium De

Leadership was needed—and the Illinois State Medical Society provided it. The ISMS Committee on Maternal Welfare believed the public has a right to know the medical issues in the growing controversy over the Illinois abortion law. With the approval of the Board of Trustees, therefore, the committee sponsored a public symposium on abortion March 15 at Chicago's Sherman House.

Because of the import of the subject, Field Enterprises Inc., another public service-minded organization, assisted ISMS in its promotion through its vast network of facilities including Chicago station WFLD-TV, the *Chicago Daily News* and the *Chicago Sun-Times*.

The *Daily News* helped create interest in the Symposium with a series of informative articles on abortion. Then, on symposium day, WFLD-TV moved its cameras and technical crew into the Sherman House to tape the proceedings. Cameras recorded arguments by eight medical specialists—representing obstetrics, pediatrics, psychiatry and public health—for and against changing the law. That night—in the prime viewing hours between 8 p.m. and 10 p.m.—WFLD-TV telecast the ISMS symposium into thousands of homes. To measure public opinion on abortion, the station ended the program with eight questions. Viewers were asked to submit their views on abortion on WFLD-TV ballots published in the *Sun-Times* and the *Daily News*. More than 1,000 viewers responded. The *Daily News* provided comprehensive coverage of the symposium and the *Sun-Times* gave it excellent photo coverage.

Public interest in the symposium was apparent to news media as the proceedings were covered by all four Chicago newspapers, the Associated Press, five television stations, three radio stations and several medical publications.

We want your opinions on abortion laws.

Should our current abortion laws be eased?
Should they be strengthened?
Watch the Illinois State Medical Society debate the questions. See expert medical minds explore the issues. Then take the home viewer opinion survey.
A public service discussion show.
Tonight at 8. On WFLD-TV.

Here is your answer sheet for the discussion show on abortion laws. Questions will be asked tonight at 8:00. On WFLD-TV.

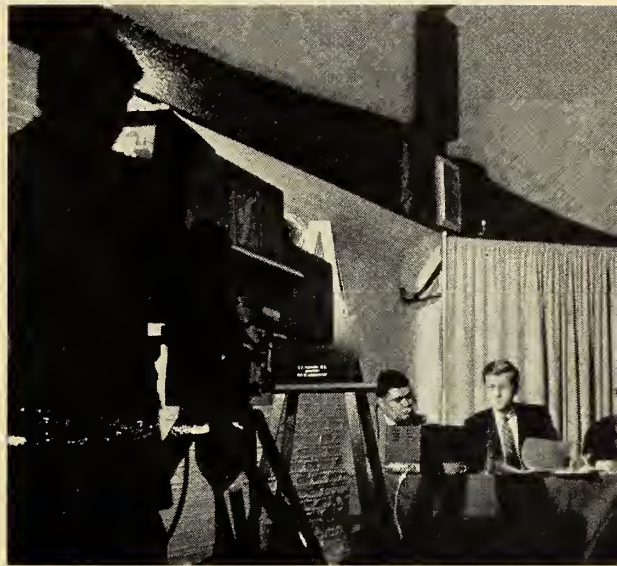
- | | |
|--|---|
| 1. <input type="checkbox"/> yes
<input type="checkbox"/> no | 5. <input type="checkbox"/> yes
<input type="checkbox"/> no |
| 2. <input type="checkbox"/> yes
<input type="checkbox"/> no | 6. <input type="checkbox"/> under 21
<input type="checkbox"/> 21-35
<input type="checkbox"/> 36-50
<input type="checkbox"/> Over 50 |
| 3. <input type="checkbox"/> yes
<input type="checkbox"/> no | 7. <input type="checkbox"/> male
<input type="checkbox"/> female |
| 4. <input type="checkbox"/> yes
<input type="checkbox"/> no | 8. <input type="checkbox"/> single
<input type="checkbox"/> married
<input type="checkbox"/> widowed
<input type="checkbox"/> divorced |

Send answer sheet to OPINION, BOX 3342,
MERCHANDISE MART STATION, Chicago, Illinois 60654

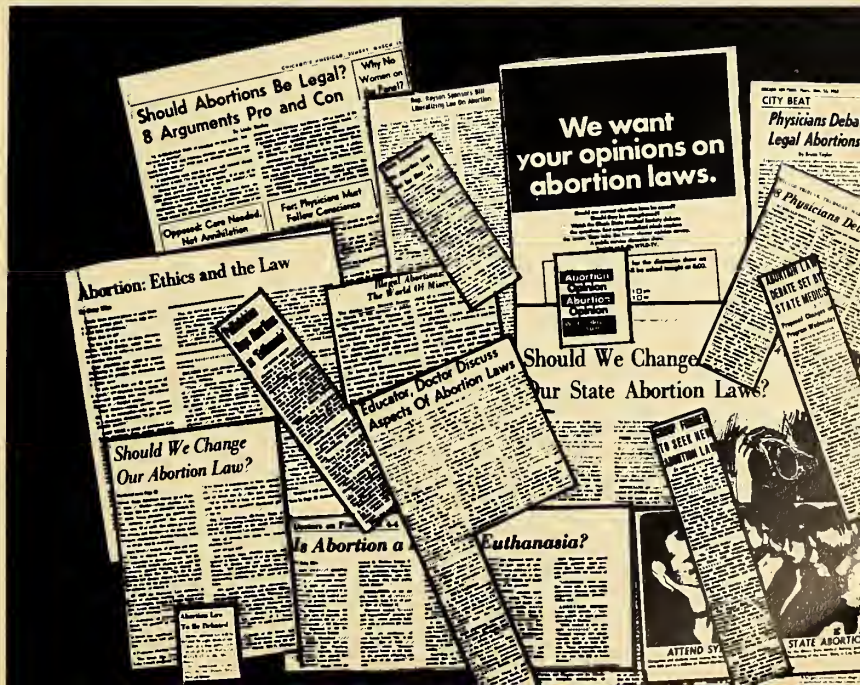


The ballot at left was published by station WFLD-TV in the *Chicago Sun-Times* and *Chicago Daily News*. Viewers were asked eight questions at the end of the two-hour program and were asked to return marked ballots to the station.

Large Press Coverage



A pediatrician's viewpoint on changing the abortion law is presented by Dr. Franklin Munsey (above left photo) at ISMS abortion symposium. Host on the WFLD-TV telecast of the symposium was Bob Hale (above right photo). The audience of more than 270 listened attentively (center photo) and asked many questions of panelists at afternoon session. Newspaper coverage was extensive, as photo at right illustrates.



The House of Delegates

By EDWARD M. CANNADY, M.D.,
Speaker of The House of Delegates
WITH FRANCES C. ZIMMER

Who Belongs to The House of Delegates:?

- 102 delegates from "downstate counties"
- 86 delegates from Cook County—CMS
 - 5 officers (president, president-elect, 2 vice presidents and the secretary-treasurer)
 - 2 speaker and vice speaker
- 16 trustees
 - 1 trustee-at-large
 - 2 AMA officers (Bornemeier as AMA Speaker of the House and Montgomery as AMA Trustee)
 - 7 AMA delegates from ISMS (the other 4 are trustees)
- 14 past presidents of ISMS
- 221 total voting power.

See CHAPTER III, HOUSE OF DELEGATES, Section 1 of the ByLaws

When and How Can an Alternate Be Seated?

The Bylaws give specific instructions to the Committee on Credentials. A delegate whose credentials have been accepted and whose name is on the roll call (as published in the April issue of the Illinois Medical Journal or furnished the committee by the Secretary), shall REMAIN a delegate until the adjournment of that session.

If a delegate, once seated, is unable to be present at any session of the House for reasons acceptable to the Committee on Credentials, an alternate may be certified, and seated.

BUT AFTER THAT ALTERNATE HAS BEEN SEATED, HE CANNOT BE REPLACED.

How Are Members of The House of Delegates Elected?

1. By the county medical societies

One for every 75 members or major fraction thereof.

1 for	75 to 113	$(75 + 38 = 113)$
2 for	114 to 188	$(75 \times 2 + 38 = 188)$
3 for	189 to 263	$(75 \times 3 + 38 = 283)$
		etc.

but each component society which has made its annual report and paid its assessment—shall be entitled to one delegate. (Bylaws CH III, Section 5)

Why Is a Membership Poll Rarely Necessary?

The House of Delegates of the Illinois State Medical Society (corresponding to the House of Representatives in Washington) is the duly elected body representing the membership of the Illinois State Medical Society, with one representative elected "for every 75 members, or major fraction thereof." This body is charged with the responsibility of expressing the official opinions of the electorate, and being well informed of the thinking of his "constituents." Therefore, when a vote is taken of the House of Delegates, it should represent the "grass roots" opinions expressed through duly elected representatives.

Very seldom is it necessary to poll the membership between meetings of the House. When such a need arises, the Board of Trustees makes such a decision and takes such an action since it is charged with the responsibility of acting in the interim, and with the authority to expend the funds necessary to conduct such a poll.

What Is the Function of The House of Delegates?

- A. The House is the legislative body of the Illinois State Medical Society and unless the Bylaws provide otherwise, its actions are binding upon the officers and Board.
- B. The House sets the basic policy and philosophy for the Society.

How Does the House Elect Officers?

The elected delegates meet in informal caucus (downstate and Chicago) and review the slate to be elected.

In 1967 the divisions are:

President-Elect	CMS
1st Vice President	Downstate
2nd Vice President	CMS
Secretary-Treasurer	Downstate
Speaker	CMS
Vice Speaker	Downstate
AMA Delegates	



Edward M. Cannady, M.D.
Speaker of the House

Trustees whose three year terms expire:

- 3rd District: William E. Adams and Ted LeBoy
- 4th District: Paul P. Youngberg
- 5th District: Darrell H. Trumpe
- 7th District: Arthur F. Goodyear
- 8th District: William H. Schowengerdt

The delegates from the various districts meet together and arrive at a decision relative to a trustee to represent them, and their recommendation is accepted by the "caucus." Then an official nominating committee presents a single "slate" to the House for consideration.

Further nominations from the floor are requested, and if none are heard, the nominee from the caucus, presented by the Nominating Committee, is declared elected. Otherwise a vote by ballot results.

The same general procedure exists in the selection of committee personnel.

How Does The House Function?

Through reports from all officers (including an audit and financial statement together with budgets as a part of the Treasurer's report), trustees, AMA delegates, committee chairmen, etc., which are referred to reference committees, reviewed and reported to the House for final action.

Through resolutions which are introduced by county medical societies through their duly elected delegate or delegates, or by any individual member of the House. These resolutions also are referred to the

correct reference committee, reviewed and the recommendation of the reference committee reported to the House for final action.

The House may approve, disapprove, remand to the reference committee for reconsideration, amend from the floor, etc., until final action is taken. Only the House can take final action and no report of any reference committee has any status until the House has so acted.

The reference committees carry the work



load for the House. Open hearings are held to discuss specific reports at a definite time and place. Any member of the House may speak, subject to the rules established by the committee. Any member of the Society may be heard, and the committee may request consultation or information from any individual it deems well informed and able to give counsel.

After the hearing, the committee goes into executive session and prepares its report for the House, presenting what it considers the best decisions possible to represent the general feelings of the majority.

If any member (or members) of the reference committee cannot agree with the majority report, they may develop and submit for the consideration of the House, a minority report in the same manner.

Preparation of Reports.

In the interest of conserving time and energy, and for the sake of efficiency, the chairman, after the reference committee arrives at an acceptable consensus, usually prepares the report. The members check the rough draft. The material is multilithed and an official copy signed by all committee members agreeing with the opinions expressed. This copy is official and turned over to the secretary of the Society.

After the House takes official action, the report (as submitted, or as amended) becomes official, and remains the policy of the Illinois State Medical Society until such action is reversed by the House itself.

The actions of the House represent the "majority rule," and must be regarded as such.

Those who differ must abide by the decisions, but may become the "loyal opposition."

Why Can't the Vice Presidents Vote on Questions Before the Board of Trustees?

The Vice Presidents (the First Vice President especially) sit on the Board of Trustees to become familiar with all the activities, problems and actions in which the president of the Society is involved. They are to "act for and perform such duties for the president as he shall direct." They shall, when so acting, implement and advance the programs and the policies of the president.

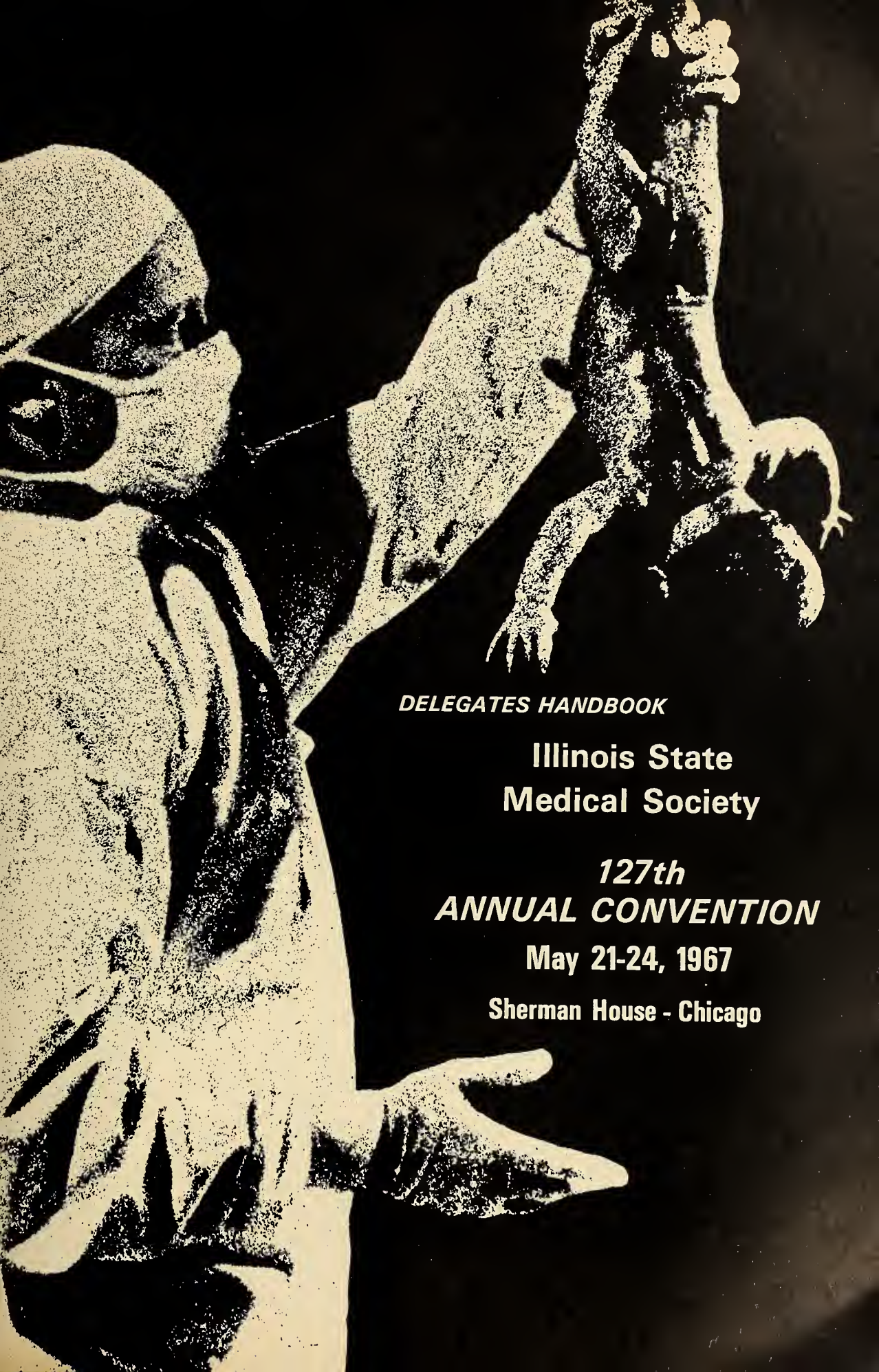
A difference in opinion between the president and the vice president might result in a cancellation of the vote of the president of the Society, a situation which would not add or enhance the highest position to which a member of this society can be elected.

How Is a Resolution Prepared?

How Is It Introduced?

- (1) A resolution must be introduced by a member of the House of Delegates.
- (2) If at all possible, (and to give the resolution status) it should have been approved by a county medical society for introduction by a duly elected delegate.

(Continued on page 582)



DELEGATES HANDBOOK

**Illinois State
Medical Society**

**127th
ANNUAL CONVENTION**

May 21-24, 1967

Sherman House - Chicago

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President Elect Newton DuPuy
1st Vice President Noel G. Shaw
2nd Vice President Paul W. Sunderland
Secretary-Treasurer Jacob E. Reisch
Speaker Edward W. Cannady
Vice Speaker Maurice M. Hoeltgen

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Second District
Third District William M. Lees, Frank J.
Jirka, Philip G. Thomsen, J. Ernest Breed,
William E. Adams, Ted LeBoy
Fourth District Paul P. Youngberg
Fifth District Darrell H. Trumpe
Sixth District Mather Pfeiffenberger
Seventh District Arthur F. Goodyear
Eighth District Wm. H. Schowengerdt
Ninth District Charles K. Wells
Tenth District Willard C. Scrivner
Eleventh District Joseph R. O'Donnell
Trustee-at-large Burtis E. Montgomery

PAST PRESIDENTS

Everett P. Coleman 1945-1946
Harlan English 1964
Rolland L. Green 1937
Edwin S. Hamilton 1962
H. Close Hesseltine 1961
Percy E. Hopkins 1949
James H. Hutton 1940
Willis I. Lewis 1954
George F. Lull 1963
Irving H. Neece 1948
Raleigh C. Oldfield 1959
Edward A. Piszczek 1965
Leo P. A. Sweeney 1953
Arkell M. Vaughn 1955

OFFICERS OF THE AMERICAN MEDICAL ASSOCIATION

Walter C. Bornemeier,
Speaker of the House of Delegates
(also a member of the Illinois Delegation)
Burtis E. Montgomery,
Member of the Board of Trustees
(Also a past president
of Illinois State Medical Society)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Walter C. Bornemeier (duplicate—Officer of the
AMA)
Edward W. Cannady (duplicate—Speaker of
ISMS House)
Harlan English (duplicate—Past President)
William K. Ford
Frank H. Fowler
Arthur F. Goodyear (duplicate—Trustee, 7th
District)
H. Close Hesseltine (duplicate—Past President)
Maurice M. Hoeltgen (duplicate—Vice Speaker,
ISMS House)
Burtis E. Montgomery (duplicate—Past President,
ISMS; Member, AMA Board of Trustees)
H. Kenneth Scatliff
Leo P. A. Sweeney (duplicate—Past President)

EX-OFFICIO MEMBERS OF THE HOUSE

(without the right to vote)

Earl H. Blair, Chicago (Councilor for the 3rd
District)
Walter C. Bornemeier, Chicago (Councilor for the
3rd District)
Fred C. Endres, Peoria (Trustee of the 4th
District)
Willard W. Fullerton, Sparta (Trustee of the 10th
District)
Lee N. Hamm, Lincoln (Trustee of the 5th District)
George A. Hellmuth, Chicago (Councilor of the
3rd District) (now living in Wisconsin)
Bernard Klein, Joliet (Trustee of the 11th District)
Charles O. Lane, West Frankfort (Councilor of
the 9th District)
Warner H. Newcomb, Jacksonville (Councilor of
the 6th District)
G. C. Otrich, Belleville (Councilor of the 10th
District)

CHICAGO MEDICAL SOCIETY DELEGATES AND ALTERNATES

Aux Plaines Branch

<i>Delegates</i>	<i>Alternate Delegates</i>
Joseph C. Sodaro	Gustav Hemwall
Clair M. Carey	Craig D. Butler
John S. Hyde	George Chobot
C. Otis Smith	Chester Thrift
William Ashley	Everett Nicholas

<i>Delegate</i>	<i>Alternate</i>	<i>Delegate</i>	<i>Alternate</i>
Charles J. Weigel	Michael J. Parenti	Wm. B. Stromberg, Sr.	John B. Murphy
A. Everett Joslyn, Jr.	Robert C. Muehrcke	Willis Diffenbaugh	Samuel T. Gerber
Arthur Gene Lawrence	Roland Kowal	Joseph R. DeCaro	Frank M. Quinn
<i>Calumet Branch</i>		William O. Ackley	David T. Petty
Eugene F. Diamond	Thaddeus C. Fial	Philip M. Bedessem	George C. Markoutsas
Stanley E. Ruzich	Donald F. Farmer	<i>North Side Branch</i>	
Robert E. Lee	Nestor S. Martinez	Michael H. Boley	Joseph Sherrick
<i>Douglas Park Branch</i>		Roland R. Cross	R. Gilchrist
John D. McCarthy	Gilbert R. DeMange	Samuel L. Andelman	Carl Hedberg
Raymond Nemecek	Miles Cermak	William A. Hutchison	Bernard T. Peele
Edward A. Razim	Arthur F. Reimann	Coye C. Mason	Marvin A. Rosner
Colman J. O'Neill	Robert F. Cesafsky	Vincent C. Freda	Richard Perritt
L. S. Tichy	Paul Zettas	Jack Williams	Benjamin F. Lounsbury
<i>Englewood Branch</i>		Erwin M. Patlak	Gustav L. Kaufmann
M. Gino	S. Hamilton	Clifton L. Reeder	Joseph Schifano
Edw. Krol	John Krolkowski	James P. Fitzgibbons	Lydia Nikurs
F. Kwin	Jos. Patka	<i>Northwest Branch</i>	
F. Saletta	Kosme Kapov	<i>Delegates</i>	<i>Alternate Delegates</i>
Wm. Nainis	John Meyer	M. A. Rydelski	Arthur J. Broder
<i>North Suburban Branch</i>		Richard V. Kochanski	Chester Podgorski
David R. Barum	Billy D. Reeves	N. J. Kupferberg	Alexander Reynarowych
Harold Lueth	Howard C. Burkhead	Michael J. Kutza	J. M. Smialek
C. Malcom Rice, Jr.	James W. Ford	I. P. Lombardo	Louis A. Wajay
John L. Savage	Donald E. Hansen	Alfred A. Zanette	
William Harridge	James R. Dillon	<i>South Chicago Branch</i>	
Arnold L. Wagner	Stanley E. Huff	John M. Coleman	William J. Marshall, Jr.
William G. Cummings	Harold G. Wedell	Casper M. Epsteen	John A. Caserta
Frank W. Pirruccollo	Martin M. Fahey	Morris T. Friedell	Maynard I. Shapiro
Raymond H. Conley	Jerome T. Paul	Simon Y. Saltman	Francis P. Malloy
William J. FitzPatrick	John W. O'Donnell	<i>South Side Branch</i>	
<i>Irving Park Suburban Branch</i>		Quentin Young	Jacob M. Epstein
<i>Delegates</i>	<i>Alternate Delegates</i>	Robert R. Mustell	Maurice Gleason
George C. Turner	Justin Fleischmann	Alfred S. Klinger	Solomon Green
Arthur T. Haebich	Frank J. Haufe	<i>Southern Cook County Branch</i>	
Thomas J. Conley	Philip H. Heller	Cyril Gallati	Gerard Gnade
Alfred J. Faber	Martin P. Meisenheimer	Frederick Weiss	C. R. Heidenreich
George Holmes	Vincent Sarley	Robert Van Etten	Hyman Love
Eugene Broccolo	Sanford Franzblau	<i>Stock Yards Branch</i>	
David Dale	Kenneth Maier	Glenn A. Burckart	Frank J. Nowak
Eugene Narsete	H. Paul Carstens	Edwin J. Lukaszewski	Joseph M. Ruda
Allen Hrejsa	Alexander Ruggie	<i>West Side Branch</i>	
<i>Jackson Park Branch</i>		George Kaiser	Eugene T. Hoban
Wright R. Adams	Julius E. Ginsberg	Anna Marcus	George Rezek
Andrew J. Brislen	Chester C. Guy	Joseph F. O'Malley	Louis S. Varzino
William J. Hand	Henrietta Herbolzheimer	<i>At-Large</i>	
David S. Fox	Harry L. Hunter	Allison L. Burdick, Sr.	Warren W. Young
Loran H. Dill	Daniel J. Pachman	Harold A. Sofield	Francis Young
Charles P. McCartney	Myron M. Hipskind	Noel G. Shaw	Fred A. Tworoger
<i>North Shore Branch</i>		DOWNSTATE DELEGATES AND ALTERNATES	
George H. Irwin	Rocco V. Lobraico	ADAMS COUNTY—6th District	
Burton J. Soboroff	Kenneth Penhale	Richard R. Cooper	Harold Swanberg
Clarence A. Norberg	Joseph H. Skom	ALEXANDER COUNTY—10th District	
Chester L. Crean	Arthur V. Bergquist	Howard D. Stuckey	Charles L. Yarbrough
Philip R. McGuire	Robert J. Jensik		
Herschel Browns	Eugene J. Ranke		

<i>County</i>	<i>Delegate</i>	<i>Alternate</i>
BOND COUNTY—7th District	Boyd McCracken	Max Fraenkel
BOONE COUNTY—1st District	John H. Steinkamp	M. Paul Dommers
BUREAU COUNTY—2nd District	George Giffin	Louis Lukancic
CARROLL COUNTY—1st District	Lemuel B. Hussey	B. V. Gunnarsson
CASS-BROWN COUNTY—6th District	B. A. DeSulis	James J. Hea
CHAMPAIGN COUNTY—8th District	Richard E. Schaeede	Donald G. Rumer
	Clarence H. Walton	H. J. Kolb
CHRISTIAN COUNTY—7th District	R. B. Siegert	R. M. Seaton
CLARK COUNTY—8th District	Eugene P. Johnson	George T. Mitchell
CLAY COUNTY—7th District	H. D. Fehrenbacher	L. L. Hutchens
CLINTON COUNTY—7th District	F. H. Ketterer	Wilson L. DuComb
COLES-CUMBERLAND COUNTY—8th District	Joseph R. Mallory	Mack W. Hollowell
CRAWFORD COUNTY—8th District		
DEKALB COUNTY—1st District	John W. Ovitz	Frank Luedtke
DEWITT COUNTY—5th District	George Castroville	H. L. Meltzer
DOUGLAS COUNTY—8th District	Elmer S. Allen	Walter G. Steiner
DUPAGE COUNTY—11th District	Morgan Meyer	Arthur P. LeBeau
	James P. Campbell	F. C. Kuharich
	J. P. Schweitzer	B. L. Rodkinson
	William E. Hill	Ralph Ryan
EDGAR COUNTY—8th District	J. M. Ingalls	Joseph R. Shackelford
EDWARDS COUNTY—9th District	Andrew Krajec	Paul S. Nierenberg
EFFINGHAM COUNTY—7th District	P. C. Rumore	Henry J. Poterucha
FAYETTE COUNTY—7th District	S. W. Moore	J. H. Weiner
FORD COUNTY—11th District	Ross Hutchison	
FRANKLIN COUNTY—9th District	H. L. Lewis	John P. Pope
FULTON COUNTY—4th District	Keith H. Frankhauser	Paul D. Reinertsen
GALLATIN COUNTY—9th District	W. F. Stanelle	John E. Doyle
GREENE COUNTY—6th District		
HANCOCK COUNTY—4th District	C. W. Bruehsel	Byron I. Mueller
HENDERSON COUNTY—4th District	Silvino Lindo	Harold Bock
HENRY-STARK COUNTY—4th District	Paul M. Schmidt	William D. Larson
IROQUOIS COUNTY—11th District	R. Kent Swedlund	James Dailey
JACKSON COUNTY—10th District	J. A. Petrazio	

<i>County</i>	<i>Delegate</i>	<i>Alternate</i>
JASPER COUNTY—8th District	Don L. Hartrick	C. O. Absher
JEFFERSON-HAMILTON COUNTY—9th District		
JERSEY COUNTY—6th District		
JO DAVIESS COUNTY—1st District	C. George Ward	Ray E. Logan
JOHNSON COUNTY—10th District	E. A. Veach	
KANE COUNTY—1st District	Donald Schleifer	H. W. Bruskewitz
	B. F. Shirer	J. L. Bordenave
	Wayne N. Leimbach	Peter Starrett
KANKAKEE COUNTY—11th District	Dale M. Learned	Charles Allison
KENDALL COUNTY—11th District	Ray C. Crawford	Victor Smith
KNOX COUNTY—4th District	J. J. Holland	William Johnson
LAKE COUNTY—1st District	Donald C. Nellins	Earl V. Klaren
	Charles U. Culmer	Kenneth L. Morris
	Michael J. McAndrew	John Andrews
LASALLE COUNTY—2nd District	William Scanlon	
LAWRENCE COUNTY—8th District	Gilbert Miller	C. G. Stoll
LEE COUNTY—2nd District	William A. McNichols, Jr.	Charles H. LeSage
LIVINGSTON COUNTY—2nd District	Don L. Ervin	Dean G. Peterson
LOGAN COUNTY—5th District	Glen E. Tomlinson	Wayne J. Schall
MCDONOUGH COUNTY—4th District	V. Burdette Adams	Donald H. Dexter
McHENRY COUNTY—1st District	James F. Harris	Wm. J. Marinis
McLEAN COUNTY—5th District	L. T. Fruin	A. E. Livingston
MACON COUNTY—7th District	Maurice D. Murfin	H. J. Burstein
	C. Elliott Bell	C. F. Downing
MACOUPIN COUNTY—6th District	Joseph J. Grandone	T. Weatherford
MADISON COUNTY—6th District	E. K. DuVivier	James Adams
	W. W. Bowers	Ben Berman
MARION COUNTY—7th District	Karl Venters	M. Herschfelder
MASON COUNTY—5th District	Jack Means	Donald Stehr
MASSAC COUNTY—9th District		
MENARD COUNTY—5th District		
MERCER COUNTY—4th District	M. E. Conway	
MONROE COUNTY—10th District	Joseph A. Werth	Edilberto F. Maglasang
MONTGOMERY COUNTY—5th District		
MORGAN COUNTY—6th District	Albert Fricke	Ernst C. Bone
MOULTRIE COUNTY—7th District		
OGLE COUNTY—1st District		

<i>County Delegate</i>	<i>Alternate</i>	<i>County Delegate</i>	<i>Alternate</i>
R. W. Zack	A. R. Bogue	SHELBY COUNTY—7th District	
PEORIA COUNTY—4th District		O. G. Kauder	C. A. Spears
Wm. O. McQuiston	G. W. Giebelhausen	STEPHENSON COUNTY—1st District	
Norman Powers	S. M. Scalzo	T. A. Haymond	H. R. Osheroff
Fred Z. White	George J. Best	TAZEWELL COUNTY—5th District	
PERRY COUNTY—10th District		Joseph Aronoff	Rudolph A. Helden
C. E. Cawvey	J. B. Stotlar	UNION COUNTY—10th District	
PIATT COUNTY—7th District		VERMILION COUNTY—8th District	
A. O. Trimmer	W. E. Mundt	E. G. Andracki	T. E. Pollard
PIKE-CALHOUN COUNTY—6th District		WABASH COUNTY—9th District	
Myer Shulman	James E. Goodman	Ernest Lowenstein	C. L. Johns
PULASKI COUNTY—10th District		WARREN COUNTY—4th District	
A. L. Robinson	James Conger	Richard Icenogle	Kenneth Ambrose
RANDOLPH COUNTY—10th District		WASHINGTON COUNTY—10th District	
O. W. Pflasterer	W. W. Fullerton	Jerry L. Beguelin	
RICHLAND COUNTY—8th District		WAYNE COUNTY—9th District	
Charles DeKovessey	William A. Moore	Charles J. Jannings	Edward S. Talaga
ROCK ISLAND COUNTY—4th District		WHITE COUNTY—9th District	
Joseph G. Gustafson	L. S. Helfrich	S. B. Abelson	J. A. Stricklin
Theodore Grevas	C. S. Costigan	WHITESIDE COUNTY—2nd District	
ST. CLAIR COUNTY—10th District		Isaac Vandermyde	Clarence J. Mueller
William Walton	Lloyd Walk	WILL-GRUNDY COUNTY—11th District	
Vivien P. Siegel	Harold McCann	Robert J. Becker	James H. Lambert
SALINE-POPE-HARDIN COUNTY—9th District		Bruce J. Wallin	Franklin K. Bowser
John Duffey		Barry S. Seng	F. Roger Fahrner
SANGAMON COUNTY—5th District		WILLIAMSON COUNTY—9th District	
Chauncey C. Maher, Jr.	Ross Schlich	Herbert V. Fine	
Preston V. Dilts	Floyd S. Barringer	WINNEBAGO COUNTY—1st District	
Richard F. Herndon	A. R. Eveloff	L. P. Johnson	Robert E. Heerens
SCHUYLER COUNTY—4th District		F. A. Munsey	H. E. LaPlante
Henry C. Zingher	Rosemary Utter	Harold E. Zenisek	E. T. Leonard
		WOODFORD COUNTY—2nd District	
		J. C. Phifer	H. W. Riggert

Agenda for the 1967 Meeting of the House of Delegates

EDWARD W. CANNADY, *Speaker*
MAURICE M. HOELTGEN, *Vice Speaker*

FIRST SESSION

3 p.m. Sunday, May 21

1. Call to Order
Dr. Cannady
2. Invocation
Robert Mendelsohn, *Chairman*, Committee on Religion and Medicine
3. Roll Call, Report of Committee on Credentials
L. T. Fruin, *Co-Chairman*
Fred A. Tworoger, *Co-Chairman*
4. Report of the Committee on Rules and Order of Business
V. P. Siegel, *Chairman*
5. Approval of the minutes of the May, 1966, meeting of the House of Delegates
6. Remarks of the Speaker of the House
Dr. Cannady
7. Memorial Service for members of ISMS who have died since May, 1966
Jacob E. Reisch, *Secretary*
8. Introduction of representatives of Student American Medical Association
9. Introduction of representatives of Illinois Chapter, Medical Assistants Association
10. Special Report to the House of Delegates
Mrs. Newton DuPuy, *President*, Women's Auxiliary
11. Introduction of officers of other state medical societies and honored guests
Caesar Portes, *President*

12. Presentation of AMA-ERF checks to the representative of the five medical schools in Illinois

By Philip Thomsen, *Chairman*, Finance Committee

13. President's Address
Dr. Portes

14. Report to the House of Delegates
George F. Lull, *Executive Administrator*

15. Presentation of Hamilton Teaching Award of the Interstate Post-graduate Medical Association of North America

By George B. Callahan, Trustee—Interstate Postgraduate Association

To Charles B. Huggins, Professor of Surgery, University of Chicago School of Medicine

16. Introduction of any necessary supplementary reports by the chairmen

17. Announcement of the reference committees for the 1967 House of Delegates

Dr. Cannady

- A. Committee on Credentials

L. T. Fruin and Fred A. Tworoger, *Co-Chairmen*

- B. Committee on Rules and Order of Business
V. P. Siegel, *Chairman*

- C. Sergeants at Arms and Tellers

Michael J. Kutza, *Chairman*

- D. Special Reference Committee to Review Opinion Research Survey

Joseph R. Mallory, *Chairman*

- E. Reference Committee on Amendments to the Constitution and Bylaws

Edward A. Razim, *Chairman*

- F. Reference Committee on Reports of Officers and Administration

James P. FitzGibbons, *Chairman*

- G. Reference Committee on Finances and Budgets

Keith H. Frankhauser, *Chairman*

- H. Reference Committee on Economics and Insurance

Clair M. Carey, *Chairman*

- I. Reference Committee on Publications and Scientific Services

Maurice D. Murfin, *Chairman*

- J. Reference Committee on Legislation and Public Affairs

Alfred J. Faber, *Chairman*

- K. Reference Committee on Public Relations and Miscellaneous Business

Albert F. Fricke, *Chairman*

18. Introduction of resolutions and referral to correct reference committees

Dr. Cannady

19. Unfinished Business

20. New Business

21. Recess until 2 p.m. Tuesday, May 23, when the House will hear reports of the reference committees

SECOND SESSION

2 p.m. Tuesday, May 23

1. Call to Order

Dr. Cannady

2. Roll Call, Report of Committee on Credentials

Dr. Fruin or Dr. Tworoger

3. Report of the Committee on Rules and Order of Business

Dr. Siegel

4. Announcement of Scientific Exhibit Awards

Coye C. Mason, *Chairman*

5. Reports of Reference Committees

- A. Opinion Research Survey

Dr. Mallory

- B. Amendments to the Constitution and Bylaws

Dr. Razim

- C. Officers and Administration

Dr. FitzGibbons

- D. Finances and Budgets

Dr. Frankhauser

- E. Economics and Insurance

Dr. Carey

- F. Publications and Scientific Services

Dr. Murfin

- G. Legislation and Public Affairs

Dr. Faber

- H. Public Relations and Miscellaneous Business

Dr. Fricke

6. Unfinished Business

- A. Introduction of officers of other state medical societies or honored guests

Dr. Portes

- B. Other unfinished business

7. New Business

8. Recess until 2 p.m. Wednesday, May 24

THIRD SESSION

2 p.m. Wednesday, May 24

1. Call to Order

Dr. Cannady

2. Roll Call, Report of Committee on Credentials

Dr. Fruin or Dr. Tworoger

3. Report of Committee on Rules and Order of Business

Dr. Siegel

4. Elections, Report of Nominating Committee

- A. President-elect (CMS)

- B. First Vice President (Downstate)

- C. Second Vice President (CMS)

- D. Secretary-Treasurer (Downstate)

- E. Speaker of the House (CMS)

- F. Vice Speaker of the House (Downstate)

- G. Trustees

<i>District</i>	<i>Term Expiring</i>
2nd	Ralph N. Redmond, resigned (election for unexpired term to 1968)
3rd	William E. Adams, Ted LeBoy
4th	Paul P. Youngberg
5th	Darrell H. Trumpe
7th	Arthur F. Goodyear
8th	William H. Schowengerdt

H. Delegates to the American Medical Association—to take office Jan. 1, 1968, and serve for a term of two years

Terms expiring: H. Kenneth Scatliff
Walter C. Bornemeier
Frank H. Fowler
Arthur F. Goodyear
Harlan English
Edward W. Cannady
Burtis E. Montgomery
(resigned following election to AMA Board;
Term—Jan. 1, 1967, to
Dec. 31, 1968.)

I. Alternate Delegates to the American Medical Association—to take office Jan. 1, 1968, and serve for a term of two years

Terms Expiring: Harold A. Sofield
George C. Turner
Edward A. Piszczek
Newton DuPuy
Jacob E. Reisch
Carl E. Clark

J. Standing Committees as provided by the Bylaws (election will take place if the proposed changes in the Bylaws are not passed on Tuesday when the report of the reference committee is presented; in each case two members are to be elected for three-year terms

(1) Disaster Medical Care

Terms Expiring:
Max Klinghoffer
Harold C. Lueth

(2) Grievance

Terms Expiring:
A. K. Baldwin
Arkell M. Vaughn

(3) Laboratory Evaluation
Terms Expiring:
James B. Hartney
Thomas P. deGraffenreid

(4) Medical Education
Terms Expiring:

Donald H. Dexter
Clifton L. Reeder

(5) Occupational Health
Terms Expiring:
Edward C. Holmblad
Arthur E. Sulek

(6) Prepayment Plans and Organizations
Terms Expiring:
Maurice M. Hoeltgen
Michael R. Saxon

(7) Public Safety
Terms Expiring:
Julius M. Kowalski
George H. Irwin

5. Presentation of the President's Certificate to Dr. Portes as retiring president
Dr. Reisch

6. Induction of Newton DuPuy, President-elect, into the office of President of the Illinois State Medical Society
Dr. Portes

The Oath of Office
Presentation of the President's Medallion, by Dr. Piszczek, donor of the medallion to the Educational and Scientific Foundation of the Illinois State Medical Society

7. Additional reference committee reports not already presented at the second session of the House of Delegates

8. Unfinished business

9. New business

A. Fixing of per capita assessment for 1967
B. Selection of meeting place for 1970
C. Election of Emeritus, Retired & Dues Cancelled for Cause

10. Report of the Illinois Political Action Committee

Dr. Thomsen, *Chairman*

11. Adjournment, sine die

Committees for 1966 House of Delegates

COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof. The committee shall pass out and receive the attendance slips and perform such other duties as may be assigned by the speaker.

The committee shall meet at least one hour prior to the time scheduled for the opening of the House of Delegates. The present schedule is:

Sunday, May 21	3:00 p.m.
Tuesday, May 23	2:00 p.m.

Wednesday, May 24 2:00 p.m.

L. T. Fruin, *Co-Chairman*

Fred A. Tworoger, *Co-Chairman*

Michael Boley E. K. DuVivier
Quentin Young

COMMITTEE ON RULES AND ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods of procedure, and the order of business (agenda) for the sessions of the House of Delegates. It shall work in close co-operation with the Delegates.

The committee shall contact the speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

V. P. Siegel, *Chairman*

Samuel L. Andelman Norman Powers
Robert Van Etten H. E. Zenisek

The first meeting of the committee should be scheduled on Sunday morning, May 21, in order to have a report to present as the first report scheduled at the opening session of the House on Sunday afternoon.

TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot vote is scheduled, or the House goes into executive session.

Michael J. Kutza, *Chairman*

Wayne N. Leimbach
Donald C. Nellins Burton J. Soboroff

REFERENCE COMMITTEE ON REPORTS OF OFFICERS & ADMINISTRATION

Meeting: 7 p.m.

Sunday, May 21

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- The President (OA-1)
- The President Elect (OA-2)
- The 1st Vice President (OA-3)
- The 2nd Vice President (OA-4)
- The Secretary (OA-5)
- Chairman of the Board of Trustees (OA-6)
- The Trustees of the 11 Trustee Districts
- The Executive Administrator (OA-7 and OA-7A)
- The Speaker and Vice-Speaker of the House of Delegates (OA-8)
- The President of the Woman's Auxiliary (OA-9)
- The Advisory Committee to the Woman's Auxiliary (OA-10)
- The Policy Committee (the Manual as amended) (OA-11)
- The Committee to Study Committees (OA-12)
- The Ethical Relations Committee (OA-13)
- The Committee to Study District Offices (OA-14)
- The Membership Committee (OA-15)
- The AMA Delegation (OA-16)

James P. FitzGibbons, *Chairman*

C. E. Cawvey William Nainis
C. J. Jannings, III C. Otis Smith

REFERENCE COMMITTEE ON FINANCES & BUDGETS

Meeting: 7 p.m.

Sunday, May 21

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

The Treasurer (FB-1)

The Benevolence Committee (FB-2)

The Rural Health and Student Loan Fund Committee (FB-3)

The Educational and Scientific Foundation (FB-4)

Keith H. Frankhauser, *Chairman*

Paul A. Dailey A. A. Zanette
Stanley Ruzich Fred Z. White

REFERENCE COMMITTEE ON CHANGES IN CONSTITUTION & BYLAWS

Meeting: 7 p.m.

Sunday, May 21

This committee shall consider and report to the House of Delegates, its recommendations on all proposed amendments to the Constitution and By-laws.

Edward A. Razim, *Chairman*

David S. Fox John H. Steinkamp
Frank W. Pirruccello Joseph A. Werth

REFERENCE COMMITTEE ON ECONOMICS & INSURANCE

Meeting: 7 p.m.

Sunday, May 21

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Committee on Prepayment Plans & Organizations (EI-1)
- Relative Value Committee (EI-2)
- Medical Economics Committee (EI-3)
- Liaison Committee with Health Insurance Industry and Blue Cross-Blue Shield (EI-4)
- Committee on Hospital Relations (EI-5)
- Committee on Usual & Customary Fees (EI-6)
- Medical Advisory Committee to the Illinois Department of Public Aid (EI-7)
- Committee on Drugs & Therapeutics (EI-8)
- Director, Illinois Department of Public Aid (EI-9)

Clair M. Carey, *Chairman*

Robert J. Becker George W. Holmes
Eugene F. Diamond Dale M. Learned

REFERENCE COMMITTEE ON LEGISLATION & PUBLIC AFFAIRS

Meeting: 7 p.m.

Sunday, May 21

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- The Committee on Quackery (LP-1)
- Committee on Legislation (LP-2)
- Medical Legal Committee (LP-3)
- Committee on Laboratory Evaluation (LP-4)
- Committee on Narcotics (LP-5)
- Committee on Public Affairs (LP-6)

Alfred J. Faber, *Chairman*

Casper Epsteen Raymond Nemecek
Paul V. Dilts Clarence H. Walton

REFERENCE COMMITTEE ON PUBLICATIONS & SCIENTIFIC SERVICES

Meeting: 7 p.m.

Sunday, May 21

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

The Committee on Alcoholism (PS-1)
 Committee on Cancer Control (PS-2)
 Committee on Cardiovascular Disease (PS-3)
 Committee on Child Health (PS-4)
 Committee on Continuing Education (PS-5)
 Committee on Environmental Health (PS-6)
 Committee on Eye Health (PS-7)
 Committee on Maternal Welfare (PS-8)
 Committee on Medical Education (PS-9)
 Ad Hoc Committee on Problems of Medical Education (PS-10)
 Committee on Mental Health (PS-11)
 Director, Illinois Department of Mental Health (PS-12)
 Committee on Nursing (PS-13)
 Committee on Nutrition (PS-14)
 Committee on Perinatal Mortality (PS-15)
 Director, Illinois Department of Public Health (PS-16)
 Committee on Radiation (PS-17)
 Committee on Tuberculosis (PS-18)
 Illinois Medical Journal:
 The Editor (PS-21)
 The Editorial Board (PS-20)
 The Journal Committee (PS-19)
 Annual Convention:
 Committee on Scientific Exhibits (PS-22)
 Committee on Scientific Assembly (PS-23)
 Committee to Study the Convention (PS-24)

R. W. Zack, *Chairman*

Don L. Ervin Harold C. Lueth
 Robert E. Lee F. A. Munsey

REFERENCE COMMITTEE ON PUBLIC RELATIONS & MISCELLANEOUS BUSINESS

Meeting: 7 p.m.

Sunday, May 21

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

The Committee on Aging (PR-1)
 The Archives Committee (PR-2)
 The Committee on Disaster Medical Care (PR-3)
 The Fifty-Year Club Committee (PR-4)
 The Grievance Committee (PR-5)
 Advisory Committee to The Health Careers Council (PR-6)
 The Committee on Illinois Association of Professions (PR-7)
 Sub-Committee on The Interprofessional Council (PR-8)
 The Impartial Medical Testimony Committee (PR-9)
 Advisory Committee on The Medical Assistants Association (PR-10)
 The Committee on Occupational Health (PR-11)
 The Liaison Committee with The Osteopathic Association (PR-12)
 Physicians Placement Service (PR-13)
 The Committee on Public Relations (PR-14)
 The Committee on Public Safety (PR-15)
 The Committee on Rehabilitation Services (PR-16)
 The Committee on Religion & Medicine (PR-17)
 Advisory Committee to the Student American Medical Association (PR-18)

Albert F. Fricke, *Chairman*

Glen A. Burckart Richard V. Kochanski
 Theodore Grevas Myer Shulman

REFERENCE COMMITTEE TO REVIEW THE OPINION RESEARCH SURVEY

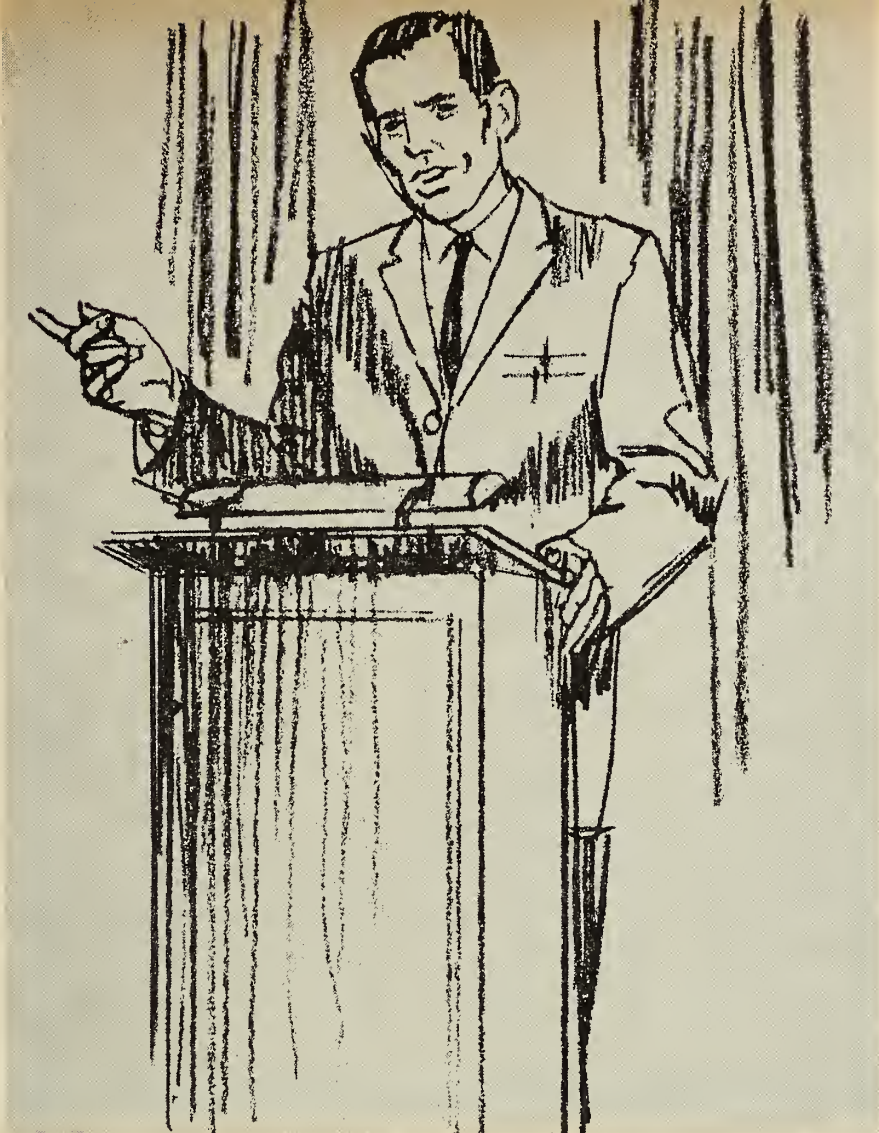
Meeting: 9 a.m.

Monday, May 22

This special reference committee will review the report of the task force appointed to study the Opinion Research Survey.

Joseph R. Mallory, *Chairman*

Morgan M. Meyer Karl Venters
 Clarence A. Norberg Warren W. Young



Officers and Administration

PRESIDENT

OA-1

As President of the Illinois State Medical Society, I represented the membership at many functions and state meetings of medical and para-medical nature. I was invited to speak at many community meetings and at the Trustee district meetings on timely subjects relating to medicine.

There were many problems during the past year.

1. Medicare with its problems of implementation, red tape, certification and recertification, billing, and of course, the problem of Title 19 with its many meetings and discussions regarding "usual and customary" fees.

2. The problem of shortage of health manpower. As we know, there is a definite shortage of doctors, especially in the rural areas. We need more family physicians. These problems were discussed by me up and down the state and I was quoted in many

newspapers, over radio and television. The problems of nurse shortage and paramedical personnel shortage have been studied and recommendations made for their remedy.

3. The problem regarding Public Law 89-239, Regional program on "Heart Disease, Cancer, Stroke and Related Diseases"—This law that was passed to create complexes or medical centers for purposes of caring for people who are suffering from diseases of heart, cancer and stroke and related diseases. My fight in this area was towards the philosophy of this law where "related diseases", of course, would encompass 95 percent of the entire practice of medicine, which means that this is more of a problem to the medical profession than even is Medicare. I tried to argue and to reason that we would favor such a program if it meant for purposes of education, continuing education of both lay people and the doctors and for purposes of research, of improving methods of treatment and finding cures if possible.

4. I fought for M.D. representation on the boards of hospitals. I felt that it is about time that the doctors took over the reins of running the hospital and that lay people not be in a position to direct and dictate to the doctors what they can and cannot do.

5. I discussed and I spoke about the image of the doctor and the way he is being critized in the newspapers, magazines, on the air, etc. These criticisms must be answered, must be replied by the profession. We have to be on the alert and respond, because if we don't, people will think that we acquiesce, that we agree. This must be the duty of the medical profession.

I have talked and discussed the problem of quackery; misrepresentation of "remedies" as cures; advertisements on TV, on radio, in the newspapers, etc. We must, for the sake of the health of this country, put a stop to this type of advertising. We must make the people understand that there are in many instances false statements made and false promises for a cure, that these people who advertise are only interested in the money they make, not in the welfare of the patient.

6. I spoke on radio, television, was interviewed and quoted in the newspapers, on the many medical problems. I cannot enumerate all the performances of the president in the past year. Let me just say that the job of the president of the Illinois State Medical Society is difficult, time-consuming, requires hard work and extreme effort.

It should have with it the dignity and the responsibility of the office. The office of the president should not be just a figurehead or rubber stamp. He should be the spokesman for the society. Many decisions are made at the present time without the knowledge or confirmation of the president. This is not usually the custom of a business organization. He should have an office at the state society headquarters where he can come in daily or as often as possible to work and to discuss problems with the staff. He should be consulted and his advice sought.

There is a chairman of the board of trustees who also has a great deal of responsibility. But I do feel that the president in conjunction with the chairman, working together, would accomplish a great deal more with less red tape.

I hope the next president will have a successful term of office and will enjoy it as much as I did. I want to thank the entire membership of the Illinois State Medical Society for the privilege of having served them as president during the past year.

I want to thank the board of trustees, the officers and the staff for their cooperation and help. The presidency of a state medical society is indeed an honor and a privilege. I will long remember it.

Caesar Portes, *President*

PRESIDENT-ELECT

OA-2

This past year has been a most pleasant one for your president-elect who has been honored to represent the president at the following affairs: AMPAC—May 21-22, Washington, D. C.; Kentucky Medi-

cal Association—Sept. 19-22, Louisville, Ky.; Illinois Nutrition Meeting—Oct. 7, Quincy; Greene County Medical Society honoring Dr. Baldwin—Oct. 31, Carrollton; AMA Convention in Las Vegas in December of 1966; and in 1967, The Illinois Health Improvement Association—Jan. 31, Springfield, and The National Chamber's 5th Association Public Affairs Conference—Feb. 1-2, Washington, D. C.

In addition, your president-elect has attended all the meetings of the board of trustees of the state society, including the dinner for the board of trustees of the AMA; all the executive committee meetings of the state society, including the meeting with the deans of the medical schools of Illinois and with the executive committee of the Illinois Hospital Association, and the AMA Convention in Chicago in June.

There will be other meetings to attend between now and May 22. Altogether it has been a challenging and most instructive year.

Newton DuPuy, *President-Elect*

FIRST VICE PRESIDENT

AO-3

It has been a pleasure to serve as first vice president of the Illinois State Medical Society. Although this is an honorary position, I have been pleased to represent the society whenever asked to do so.

I have attended the various meetings of the board and served on the Committee to Study District Administrative Offices, and as consultant to the Liaison Committee to the Illinois Hospital Association. I also attended the District II meeting.

I should like to pay tribute to the time and energy devoted to this society by the trustees and other officers, particularly your president, Dr. Caesar Portes, who has been untiring in fulfilling his many obligations.

We shall miss Mr. Richards who did an excellent job as executive administrator. We are deeply appreciative of Dr. Lull's helping out again in this capacity.

Noel G. Shaw, *First Vice President*

SECOND VICE PRESIDENT

OA-4

It was my privilege to represent Dr. Portes and our society at the annual meeting of the Indiana State Medical Association. This association has excellent organization that rotates duties among its members, maintains continuity of purpose and goals, and engenders enthusiasm. Some of the methods would be worth while considering as we continue our appraisal of the Opinion Research Survey.

I have attended meetings of The ISMS Board of Trustees and of the AMA House of Delegates in Las Vegas. These meetings were impressive. Many doctors spend many hours studying your problems, considering the policies that you have established and making decisions that affect medicine and the people of the state of Illinois. I would encourage every member to attend *one* meeting of the Board

of Trustees on a Sunday morning. The massive amount of business that is transacted on your behalf would enlighten and overwhelm you.

This year has been one of instruction. The officers, trustees and staff have been dedicated, gracious and kind in teaching me. I hope the information assimilated will provide the background for me to serve you, the members of ISMS.

Paul W. Sunderland, *Second Vice President*

SECRETARY OA-5

Report of the Secretary-Treasurer (FB-1) will be found under Finance and Budgets.

FIRST DISTRICT OA-T1

The societies of the First District have all had regular professional programs and all, especially the larger societies, have had very active public relations projects. Several will present resolutions to the House of Delegates.

No problems confronting the individual societies have been presented which were not solved at the local level.

It is planned to bring the delegates of the medical societies of the First District together for a district meeting sometime before the annual meeting. Such a district meeting was held in November, 1966. At this meeting, new members were recognized and received informational kits about the Illinois State Medical Society and its activities. Those officers and delegates attending took this as an opportunity to express their opinions and ask questions about current organizational problems.

In some of the past years, there has been considerable apathy among members of the societies, but one gets the feeling that there is a new interest in society affairs during the past year. More members have been active on state committees, both those appointed by the trustees and by the reference committees. It seems that society activity has been at a peak in 1967. Your trustee is grateful for the complete cooperation and for this record of achievement.

Carl E. Clark, *Trustee*

SECOND DISTRICT OA-T2

Ralph N. Redmond, M.D. suffered a coronary occlusion early in February and was a patient in the Community General Hospital, Sterling, for over a month.

At the time of his attack, he had his report as trustee partially completed, but was not permitted to finish it. On the advice of his physicians, he resigned as trustee and member of the Finance Committee. Doctor Goodyear, Chairman of the Board, accepted his resignations with regret.

The officers and trustees of the society will miss the close association with Doctor Redmond and extend him all best wishes for a steady and complete recovery.

George F. Lull, *Executive Administrator*

THIRD DISTRICT OA-T3

No report available.

FOURTH DISTRICT OA-T4

Component societies of the Fourth District have been active during the year of 1966 under the able administration of their officers and committees. At the time of this report, there are no resolutions to the House of Delegates at the May meeting. Monthly meetings have been held in the various counties. Many of these meetings are preceded by a social hour followed by a speaker on subjects of a medical nature. Several counties have joint meetings with the dental association and the legal profession. These meetings have proven very fruitful, resulting in a friendly atmosphere between the professions.

During the year several public service awards were presented to outdoor advertisement companies.

The loss of two of our prominent members should be mentioned. Dr. White of Kewanee, who for many years served the medical society in many capacities, and as its president, he has been missed. Dr. Blair of Monmouth, served as councilor for many years, gave much of his time and effort in behalf of the ISMS.

The most ambitious project of 1966 in Rock Island County, and one representing departure from usual activities, was the participation of the medical society in putting on a medical information television program directed primarily at the problems of medical services rather than of specific diseases. This was carried out under the direction of Public Affairs-Public Relations Committee with many of the doctors in the society appearing on a weekly program through the summer and early fall. The state medical society was extremely cooperative and helpful in organizing this television project and providing material as well as in writing newspaper articles to appear in conjunction with the television program. One of these newspaper articles on the subject of emergency rooms was converted to a pamphlet which was printed by the medical society for distribution to hospital emergency rooms and doctors' offices as a means of acquainting emergency room users with some of the problems and details of operation of the emergency rooms.

In regards to the location of a future medical school outside of the Chicago area, the Peoria Medical Society states that because of the five general hospitals with their available teaching beds, the Peoria State Hospital, the new Zellar Zone Clinic, the Institute of Physical Medicine and Rehabilitation, the Northern Regional Laboratory, the new Allied Health Agency Project, Bradley University, the St. Francis Hospital Community Clinic, and outpatient department, that this medical school should be located in Peoria.

Most of the year the members of the Fourth District have been concerned with the political, so-

cial and economic phases of medical practice. Many of the members have taken active part in the political arena which has in the past been foreign to them. Much time and energy have been given to the candidates amenable to the profession and from the results have been quite successful. Medicare with all its frustrations has led to the necessity of many meetings of instruction and it is hoped that as time goes on many amendments to the bill might be made to the satisfaction of our membership.

I wish to thank the component county medical societies for the cooperation given me during the past year, the officers of the state society, and the state society staff.

Paul P. Youngberg, *Trustee*

FIFTH DISTRICT OA-T5

This past year, the eight component societies of the Fifth District continue to be active and cooperate in state society projects. Many members of the respective societies serve on state society committees. The larger county societies hold monthly meetings with excellent scientific programs and well-conducted business meetings. The smaller county societies meet less often and by their own remarks "as needed." Attendance, for the most part continues, to be disappointing to program chairmen, and apathy and lack of understanding continue to prevail among the uninformed.

The larger county medical societies continue to practice good public relations by joint meetings involving dinners and dinner-dances with other professional groups such as the bar association, pharmaceutical association, dental association and ministerial groups. The doctors' wives and especially those involved in auxiliary activities make these events most successful.

At the time of this writing, the constitutional committees of the Fifth District, namely, the Grievance Committee, the Third Party Plans, and Ethical Relations Committees have not had occasion to meet. All problems that have arisen have been handled by the local component medical societies' committees.

The Illinois State Medical Society had another outstanding exhibit at the Illinois State Fair for the 16th consecutive year. Dr. 'SIMS' was ably assisted by the ladies of the Sangamon County Medical Auxiliary to make this an outstanding exhibit and one of great popularity with the fair-going individuals. We need to continue supporting this project.

The Sangamon County Medical Society and the ladies of the auxiliary served as hosts Dec. 8 to a Fifth District Conference. Unfortunately, this was not a scientific district meeting, but dealt with Medicare, usual and customary fees and the Illinois Public Aid Commission; 277 registered for the afternoon session and 70 remained for dinner and to hear our president, Dr. Caesar Portes give his usual stimulating address. Roger White and the members of the Springfield office did yeoman service in arrang-

ing this meeting. Mr. White and Dr. George Murphy, program chairman of the Sangamon County Medical Society assisted by the Springfield office made it very simple to have a successful district meeting.

On Dec. 1, this trustee had the privilege of representing your state society and President Portes at the 4th Illinois Conference on School Health held here in Springfield. This was a well-attended meeting dealing with "sex education" in our schools. This is a most worthwhile affiliation with other interested groups and we should continue to sponsor such endeavors.

As your trustee, I have had the privilege and good fortune to be able to attend all of the meetings of the board and also the meetings of the Journal Committee and the Committee to Study Committees to which I have been assigned this past year.

A successful meeting was held with the delegates and alternate delegates of most of the Fifth District just prior to the opening of the first meeting of the House of Delegates last year and a similar meeting is planned for this year.

May I express my appreciation for the consideration and cooperation shown to me by the delegates, the officers and the membership of the component societies. Likewise my fellow trustees, the state society officers and the executive administrator and his most capable staff in Chicago.

Darrell H. Trumpe, *Trustee*

SIXTH DISTRICT OA-T6

As a new trustee I am still becoming acquainted with my district and my responsibilities to it and to the Board of Trustees. The component county societies conduct their affairs so well that, as yet, I have not been called upon to consult with them on many local problems.

One request did come from our state office in regard to a grievance. After lengthy negotiations with the complainant, the chairman of the state Grievance Committee and the local county Grievance Committee, a meeting was arranged in which I participated; the complainant obtained his much desired "day in court" even though the outcome of the hearing was not entirely satisfactory to him. No meetings of the district Ethical Relations Committee, Grievance Committee, or the Prepayment Plans Committee have been necessary during the past year.

Several small meetings were arranged with our local state representatives in the legislature. These were informative for all participants and were valuable in getting the medical viewpoint and thinking across to our legislative representatives on a number of matters which increasingly affect our daily lives and medical practices.

I attended a number of meetings of the Bi-State Heart Cancer Stroke Advisory Council in St. Louis, Mo. It is exploring the possibility of setting up a regional program which would include some of those Illinois counties which are adjacent to the city of St. Louis. This program is still in the planning stage and is subordinate to the plans of the states

of Illinois and Missouri which have not been finalized.

It was my pleasure in October, 1966, to present a Fifty-Year pin and certificate to Dr. A. K. Baldwin, of Carrollton, at a delightful dinner arranged by Dr. Paul Dailey and Dr. A. D. Wilson. Many of Dr. Baldwin's friends and colleagues from throughout the Sixth District joined to honor him that evening. Dr. Baldwin added this honor to another bestowed on him some years previously when he was selected as "Physician of the Year" in Illinois.

In December I was pleased to testify at a hearing held in Springfield by the special committee of the State Board of Higher Education in regard to the need for a new medical school and its possible location in downstate Illinois. In my opinion, this is of great importance and is intimately associated with the larger problem of having medical aid available to our rural areas. We should not permit this void to be filled by chiropractors, and if we do not voluntarily address ourselves to solving this problem soon, it requires no seer to predict the "who and how" of its eventual solution.

I have attended all meetings of the Board of Trustees held since the last annual meeting. The number and variety of problems considered and acted upon by the board and its committees are very revealing to me as a new trustee. I have also been impressed with the ability and resourcefulness of the staff members; the guiding hand of Robert L. Richards will be sorely missed. May I express my appreciation to him and all members of the staffs in Chicago and Springfield for their helpfulness and many courtesies to me in the past year.

Mather Pfeifferberger, *Trustee*

SEVENTH DISTRICT OA-T7

There have been no basic changes during the past year in the membership throughout the Seventh District. There is, however, a need for more general practitioners.

The three district committees have been free of problems to this date.

Medicare's problems from the Utilization Committee standpoint have been giving full cooperation to the hospitals in the Seventh District. For which the hospital administrators and medical staffs are to be congratulated. Title XIX continues to be complex and solution will be slow, but we hope orderly through Department of Health Education and Welfare.

Your trustee's duties have been increased as you all know, he having been elected Chairman of the Board of Trustees of the Illinois State Medical Society. Much of his report will be in the report of the Chairman of the Board of Trustees to The House of Delegates in May, 1966.

New health facilities in the district mainly point toward Decatur. The Adolph Meyer Zone Center was dedicated and opened in October, 1966. The staff of the center has been increased and is working

well with mental health units in the counties that it serves. The Decatur and Macon County Hospital is now in process of extensive building which will add 100 to 150 more beds. The project cost is in the region of seven million dollars.

Four new members were inducted into the Fifty-Year Club in May, 1966. Drs. George J. Rivard, Jr., Edmund C. Roos and John J. Hopkins were awarded their Fifty-Year certificates and pins at the May meeting of Macon County Medical Society at the Decatur Club in Decatur. Dr. Milton E. Rose, the fourth recipient, who has retired and living in Barrington, was forwarded his pin and certificate.

The Woman's Auxiliary has been functioning actively. Your trustee is grateful for the work being done by this fine organization.

In summary, the year has been a relatively normal one except for problems created by the 1965 legislation in medicine. Appreciation is extended by your trustee for the support and cooperation of the constituent medical societies and auxiliaries.

Arthur F. Goodyear, *Trustee*

NINTH DISTRICT OA-T9

The trustee of the Ninth District has tried to fulfill his duties as trustee during the past year of being the organizer, consultant, advisor, administrator and speaker for the members of his district and represent the society as well as the members of his district at the board meetings. The larger societies have been visited and seem to have no acute problems. The members seem to be well informed about Medicare problems. All members are quite busy with their practice of medicine. Six societies of my district are quite small being composed of four to six members and seldom hold an organized meeting. These six societies seldom send a delegate to our annual meeting. It is my feeling that members of these societies feel that they cannot leave their patients for any extended period of time because of the shortage of physicians and that they do not have a keen interest in organized medicine.

No problems were presented to the district Ethical Relations Committee, the Grievance or the Prepayment Plans and Organizations Committees during the past year

During the summer I attended a meeting of the Marion County Medical Society and presented a Fifty-Year plaque and pin to Dr. Schoonover of Salem, representing Dr. Goodyear who was unable to attend.

In early November a combined meeting of the Ninth and Tenth Districts was held at Augustines Restaurant, Belleville. About 200 members attended with their wives and the highlight of the program was the evening speaker, Dr. Judd, a former U. S. Representative and medical missionary.

I wish to thank the staff of the Illinois State Medical Society for their assistance during the past year.

Charles K. Wells, *Trustee*

TENTH DISTRICT OA-T10

Dates of Visits and Events

May 31—Initial planning meet Regional Medical Center Bi-State, held at St. Louis University.

June 2—St. Clair County Medical Society meeting at Pleasant View Sanatorium. Staff organization to assist in accreditation of the sanatorium.

June 8—Presentation of graduation address, School of Nursing, Junior College, Belleville. First Class of accelerated program.

June 15—Presentation of Public Affairs award to members of Perry County Medical Society and their wives, at Traveler's Restaurant, Du Bois. Remarks on direct billing; extended care facilities; and alerting of patients that hospital based physicians, pathologists, radiologists, etc. would also send statements for their professional services. Dr. Fulk of Du Quoin is the most recent addition to the roster. Dual billing for physicians wives, excerpts from the confidential interim report on the ISMS and need for increased AMA dues mentioned.

July 26—Jackson County Medical Society meeting at Tom's Restaurant, DeSoto. Resume of AMA, state annual meeting; direct billing; heart legislation; medical school endorsement; IDAP; local society committee structure; wives' dues; foundation suggested for their \$4,000.

Aug. 16—Alexander County and Pulaski County Medical Societies meeting at Cairo. The called meeting of the Alexander County Medical Society convened at St. Mary Hospital at the direction of its president, Dr. Lewis Ent. Discussion dealt with shortage of physicians in area, high percentage of people on assistance, and the problem of providing medical care. Other subjects of discussion: utilization committee, direct billing, opinion research information and medical organization structure.

Aug. 18—Ninth annual tea given by The Women's Auxiliary to St. Clair County Medical Society in honor of scholarship recipients in joint venture with the Nurse Scholarship Association of St. Clair County. The 13 scholarships were awarded including one from a major political party presented by Charles Percy. More than 150 invited guests and dignitaries attended.

Sept. 23—Attended second planning meeting of the greater metropolitan St. Louis-Illinois Heart-Cancer-Stroke Program. Application for Heart-Cancer-Stroke Center. Committee to consult with Illinois program to avoid conflicting jurisdiction.

Oct. 13—Monroe County Medical Society meeting at Bee Hive Restaurant, Waterloo. Informal discussion with members on opinion research, utilization, nursing homes, doctor dispensing, and other current subjects. The physicians recently conducted an area-wide Tine TB testing on all age population—about 3,000 people—in conjunction with the local TB Society.

Nov. 3—Combined Ninth and Tenth Trustee District meeting at Augustines. Facts: 55 paid commercial exhibitors, 251 members and guests for lunch-

eon, 250 paid admissions for annual banquet—Dr. Walter Judd presentation on the progress of medicine and evolution of government monopoly; 86 men in attendance of respective commercial booths, 125 members attended, 84 wives and guests.

Dec. 13—Meeting with Greater St. Louis Regional Planning group for finalization of planning grant of \$500,000 for Heart-Cancer-Stroke.

Dec. 13—Representation of Tenth District at Springfield hearing of higher education—Dr. Campbell, chairman. Fifteen representatives from greater Metro-East area. "Share the Health" Commission seemed to be impressed.

Jan. 4—Representative of St. Clair County Medical Society on Station WIBV, Belleville, on subject of medical ethics. Conclusion developed—greater need for communication into charges, diagnoses, and reasons for procedures—resulting from open line inquiries.

Jan. 10—Participation in panel, Ninth District meeting Illinois Hospital Association. Subject matter: developing better liaison with medical staff and administration in hospital.

Jan. 15-17—Attended Department Health, Education, and Welfare Conference on Regional Medical Program, Washington, D. C. Represented bi-state region at this briefing meeting on region affairs.

Jan. 30-Feb. 2—Attended U. S. Chamber of Commerce Public Affairs Conference, Washington, D. C.—including ISMS hosting members of Congress.

Feb. 5—In conjunction with officers and Dr. Wells of Ninth District, planning meeting for annual meeting of Southern Illinois Medical Society in November.

Feb. 8—Washington County Medical Society, DuBois. One doctor transferred to neighboring county. Two-hour discussion on legislation, implementation of Medicare, future trends of medical service, Public Law 293 and 749.

Feb. 9—Lincoln Day Dinner, St. Clair County, attended by 175 physicians and wives to hear Sen. Everett M. Dirksen. Dr. Wilson West conveyed organized medicine's appreciation for his efforts.

Feb. 11—Randolph County Medical Society meeting. Active discussion with members and wives on national medical centers, Title 19, Public Law 749, IPAC fees, opinion research matters discussed.

Feb. 12—175 doctors, wives, clergymen, and visitors attended medical-clergy brunch and conference sponsored by St. Clair Medical Society featuring Rev. Christian Hovde, Bishop associated with Anderson Foundation. Message: Communication and Clarification.

Feb. 16—9th annual banquet Nurse Scholarship Association of St. Clair County at Augustine's; 346 people including 55 guest student nurses.

Remarks

Physicians and wives of the district manifest increasing interest in health careers, legislation, community projects and programs. Likewise, they are concerned over federal trends in medical care, in-

creasing use of emergency room services, taxes, and physician distribution. Their cooperation in all endeavors is a source of inspiration.

W. C. Scrivner, *Trustee*

ELEVENTH DISTRICT OA-T11

In the past year your trustee attended all the quarterly meetings of the Board of Trustees, the annual meeting of the AMA in June, and the mid-year meeting of the AMA in Las Vegas. Also, I attended the Public Affairs Conferences in Washington, D. C., in February wherein much informative material and exchange of ideas was obtained on the national political scene. Further, I sat on two committees of the board, viz., The Committee on Committees and the Committee on Usual and Customary Fees. Both of these committees were very active and the report of these committees should be reviewed thoroughly by the membership at large.

The Opinion Research Survey of last year again emphasized the needs of improving the communications line between the trustee and the county medical societies he serves. It also demonstrated the need for increased participation by individual M.D.s at the state society level. I am again impressed by the tremendous volume of business that goes through a quarterly meeting of the board and by the importance of getting this information disseminated to the county medical societies as complete and expeditiously as possible. It would be of interest to have an officer of each medical society attend a meeting of the board, in order to acquaint them with the proceedings as they occur.

A district meeting of the Eleventh District is scheduled for Mar. 29 for the purpose of (1) acquainting the members with current problems affecting the ISMS and (2) to formulate any additional resolutions to the House of Delegates meeting in May.

Several thoughts occur to me re the position of trustee.

(1) Other state medical societies limit the tenure of office of a trustee in that he may succeed himself only one time in office, (i.e., a maximum of six years). The district may then have an option of returning this man to office at a later date if it so desires. During the interim his service would be of value working with committees, (or as a local or national delegate), wherein he had special interests.

(2) An "alternate" trustee could be appointed in some fashion to attend board meetings. Here, a wider spread of communications could be expected to the local medical societies, as well as being a good "proving ground" for future trustees.

Time has proven that as our medical world becomes more complex with respect to both social and technological advances, it is more and more demanding of the individual to take the responsibility of representing the entire medical profession in meeting their problems.

J. R. O'Donnell, *Trustee*

TRUSTEE-AT-LARGE OA-TAL

This year has certainly been a let down insofar as activities are concerned. Once one becomes a past president his duties also become less and the burden of travel, and so forth, becomes less of which of course is very much appreciated.

It has been a great pleasure for me to have served the Illinois State Medical Society for a long period of time, to have served you as your president, and to have had some part in the re-organization and the establishment of a fine staff which we have had for the past six years. This I hope we will continue.

My activities with the state medical society this year have consisted mainly in attending the meetings of the Board of Trustees, the various committees to which I am attached, and doing the things which have been requested of me.

In bowing out from the active duties of the state medical society, I wish to express to you my appreciation again for all your kindnesses, but I want you to know also that I am available if you need any consultation or any work in which I might do for the society.

When one once becomes saturated with medical society work, his interest never ceases. This I hope ours will never do because I think we have a fine state medical society and I would desire to see it continue as such.

Please accept my most sincere appreciation for all the kindnesses which all of you have shown to me over the years I have served the society.

B. E. Montgomery, *Trustee-at-Large*

CHAIRMAN BOARD OF TRUSTEES OA-6

As a member of the board since early in the 1950's, I have seen the work load of organized medicine double, and triple. I have watched the affairs of the Illinois State Medical Society become "big business," and I have witnessed the growth and development of the American Medical Association until both these medical organizations require an alert, well informed and actively participating membership and headquarters staff.

Under the direction of Mr. Richards, the Illinois State Medical Society made the necessary transition and assumed its position as the fourth largest medical society in the country and made a new impression on the members (perhaps via the individual pocketbook, since awareness many times is based upon financial expenditures). At the time Mr. Richards informed me, as Chairman of the Board, that he planned to leave the medical society for a position with industry, the Executive Committee met and expressed a definite desire to "have a doctor in the house" if at all possible.

Fortunately, Dr. George F. Lull was available to serve for 18 months, during which time he will assume the responsibility of the headquarters office and assist in training a successor.

While the national trend in the administrative field of medical society executives has been toward lay executives, both New York and Massachusetts have found solutions to their headquarters administration by securing the services of a physician capable and experienced in the field of administration.

1968 DUES		
The Board of Trustees will recommend to the House of Delegates at the meeting in May, 1967, that the DUES REMAIN THE SAME FOR 1968. The projected budget is in balance, and no deficit is anticipated.		
ISMS Dues		
AMA-ERF	\$20	
Benevolence	7	
Operating Fund	70	
Permanent Reserve	8	
		\$105
AMA Dues		70
	Total	\$175
Voluntary Contribution to AMPAC-IMPAC		25
	Total	\$200

My report to the House will be concerned primarily with some of the items that came before the board and do not fall under the direct jurisdiction of any established committee. For me to report in that area would result in a duplication of effort, a duplication in the work of the House, and perhaps two reference committee reports on the same subject.

1. The Darling Case

The judgment of the court in the Darling Case (Charleston Hospital) has resulted in an opinion that the hospital as well as the physician, is responsible for the physical condition of the patients. This may place the hospitals in the practice of medicine under the law.

Mr. Frank M. Pfeifer, legal counsel for the society, reported the details of the case to the trustees, and stressed the importance of a physician discussing his case with the patient in language the patient can understand, securing the co-operation of the patient, and his permission for procedure.

The importance of keeping meticulous records, using consultants, carrying adequate and quality insurance, participating in frequent post-graduate programs, were all part of Mr. Pfeifer's recommendations. These are all basic facts and should be obvious to physicians aware of their responsibilities not only to patients, but also to themselves as members of the medical profession.

2. Illinois Mastitis Council

Last spring, a joint meeting was held with representatives of the Illinois Department of Agriculture, the Illinois Dairy Industry and the Illinois Department of Public Health. This group ap-

proved the formation of the Illinois Mastitis Council to promote statewide bovine mastitis eradication under a controlled program. This disease costs the Illinois dairy farmers over \$14,-000,000 annually, while treatment costs some \$700,000. The Illinois State Medical Society officially sent commendation to the dairy industry, and pledged support of the program.

3. The AMA "National Community Service Division"

The American Medical Association is developing a "National Community Service Division" to secure speakers (at least two each year) on health subjects for community civic groups, service clubs, women's organizations, etc. The division will encourage physicians to join local clubs, serve on committees and participate in community activities. Influence at the grass roots is the aim of the new division, and the personnel will furnish aid to members of the profession and the auxiliary.

It is hoped that this division will develop courses in leadership, train physicians in the presentation of health subject, and provide the general "know how" for participation at the local level.

This service replaces the former speaker's bureau.

The Bi-State Regional Committee on Heart Disease, Cancer and Stroke (St. Louis Metropolitan Area) requested participation by physicians in St. Clair and Madison counties including the ISMS trustees from the respective districts. The board agreed that the physicians should serve in an advisory capacity until there was further clarification of regional boundaries. The Illinois Regional Committee on Heart Disease, Cancer and Stroke has extended its regional boundaries to the entire state of Illinois.

5. Resource Committee for the President

In a report to the board, Dr. Scrivner, trustee from the Tenth District, suggested that a "resource committee" be established for the President of the Illinois State Medical Society. The last three past presidents, plus members of the Executive Committee of the board were suggested as committee personnel. This group could assist the president in following policy established by the House of Delegates, and provide liaison with other state medical societies, the press and lay organizations.

One member of the headquarter's staff should be assigned to the president to assist him in scheduling appearances before civic groups, on television or radio and other meetings, and to research the requests for his appearance before commitments are made.

6. Task Force to Study the Opinion Research Survey

The Board of Trustees asked the Chairman of the Board to appoint a task force to study and make recommendations based on the Opinion Research Survey.

The survey has been completed and will be

mailed to all members of the House of Delegates prior to the May meeting. A special reference committee, appointed by E. W. Cannady, Speaker of the House, will meet on Monday morning when no other committee is in session. All delegates are expected to attend and should be familiar with the material under consideration. The Task Force will have reports to present, based upon a study by sub-committees:

1. On Administration, Keith H. Frankhauser, *Chairman*
 2. Public Relations, Jack Gibbs, *Chairman*
 3. Legislation, Paul Van Pernis, *Chairman*
 4. Scientific Services, Coye C. Mason, *Chairman*.
- These men will be present to answer questions, and to help the delegates interpret the material presented in the survey.

7. Salary Continuation Insurance

Salary continuation insurance for employees has been established. The society will pay full salary to employees for three months, then the insurance carrier will take over, and assume 50 percent payment. Employees may elect to carry additional coverage of their own.

8. Refresher Course for Physicians with Limited Licenses

The Illinois State Medical Society approved the proposed refresher courses for physicians with limited licenses working in state hospitals. Dr. Robert Drye, Director of Education of the Illinois Department of Mental Health, reported to the board on the program. The Department of Mental Health provided the funds to pay the participating faculty and developed the program to assist the physicians in the state institutions who were interested in self-improvement by providing the post-graduate training. Sessions held in 1966 were well attended. The 90 participating physicians will benefit, as well as the patients entrusted to their care in state hospitals. The program will be continued as long as funds are available and the need exists.

9. Meetings with Illinois Hospital Association

The Executive Committee of the Illinois State Medical Society and the Executive Committee of the Illinois Hospital Association met Dec. 15. Future meetings of these two groups are to be planned by Dr. Lull as Executive Administrator of the state society, and Mr. David Kinzer of the Hospital Association.

10. Minutes of the Board of Trustees

Recently, the official minutes of the board have been mailed to approximately 800 members of the society including the officers and trustees, the AMA delegates and alternate delegates, the ISMS delegates and alternate delegates and the presidents and secretaries of county and branch societies. Only one comment has been received in the headquarters office.

Now we wish to ask the House for an expression of opinion. Does this extensive mailing help in the problem of communications? Do you, as delegates to the House, read and study the problems

faced by the board and the officers of the society? Does it help to keep you in touch with the extensive and varied activities of the committees working out of headquarters office?

Have you studied the quarterly financial statement furnished during the past year at the request of the 1966 House?

Has this expense been justified?

RESOLUTIONS REFERRED TO THE BOARD

1966 House of Delegates

Resolution #18 "Availability of Hospital Records to Insurance Carriers"

This resolution came to the attention of the Policy Committee and a policy statement has been developed which is contained in the manual for the consideration of the House.

Also, the resolution requests that the society instruct an appropriate committee to gather any data necessary to justify the policy followed by the two hospitals in Decatur.

At the present time the Committee on Prepayment Plans and Organizations has this resolution under consideration. A meeting has been held with the representatives of the Illinois Hospital Association and the Illinois Record Librarians and when some definite information is available it will be reported.

Resolution #66-19 "Need for Lay Administrators at County Society Level"

This resolution, introduced by Will-Grundy County Medical Society was amended, and referred to the Board of Trustees.

As amended, the resolution requested that the officers of the Illinois State Medical Society, or the Board of Trustees, appoint an ad hoc committee, which together with the Illinois State Medical Society executive office, will investigate, assist and educate the component medical societies relative to the possibilities of their obtaining lay administrative offices, either in conjunction with neighboring medical societies, or with other professional organizations.

This ad hoc committee has been appointed by the Board of Trustees with Dr. Robert J. Becker as the chairman. Its first report to the House of Delegates will be presented in May.

Resolution #66M-20 "Opinion poll prior to meetings of House of Delegates at state level—Similar poll prior to meetings of AMA House to reflect national thinking."

This resolution, as amended was "referred to an appropriate committee to investigate a mechanism of instituting a polling or opinion-seeking device for the purpose of informing delegates to the Illinois House of Delegates, and the Illinois Delegates to the AMA House of Delegates, relative to current issues."

The board referred this matter to the Executive Committee for consideration. The Executive Committee reported that since the delegates from the county societies are elected to represent their constituents, the vote of these delegates represents

the recognized method of polling members on important activities.

The AMA House has considered this problem frequently and feels that its House is cognizant of the thinking of the various constituent societies. In June of 1964 the AMA House stated that the AMA News would be a suitable and rapid procedure of contacting the membership if such procedure were indicated.

Therefore, it is the thinking of the Executive Committee that the membership of the ISMS may (if necessary) be contacted through the pages of the *Illinois Medical Journal*, or through the publication *PULSE*, which is mailed to the entire membership monthly.

Anything requiring more study or more "grass roots" expression would possibly indicate a called session of the ISMS House.

Resolution 66M-33 "Need for Trained Sanitarians"

This resolution asked that "a committee be delegated to explore and promote the development of curricula and individual courses of study which would answer this need, and that all facilities of the education community, including community colleges and state universities, be encouraged to provide for such needs."

The Executive Committee of the Board of Trustees requested the Executive Administrator to "seek up-to-date information from the Director of the Department of Public Health regarding a program for the training of sanitarians, and to urge him to develop a stepped-up program of education in this area of need."

In all probability a reply from the Director of the Department will be available for members of the House at the 1967 session.

Resolution 66M-40 "Dietary Provisions for Recipients of IDPA"

This resolution dealing with the dietary allowances provided recipients of public aid, was referred to the Board of Trustees to be assigned "to the appropriate committee for study."

The board asked that the Committee on Nutrition consider this problem, and report back to the 1967 House of Delegates. Such a report will be forthcoming for the consideration of the delegates in May.

Resolution 66M-47 "Training and Development of Volunteer & Staff Leadership"

This resolution was referred to the Executive Committee and at the ISMS level, the Finance Committee has under consideration the financing of a leadership program for officers and staff of the Society.

When a program at the state level can be developed, the board will give it serious consideration.

The resolution went to the AMA at the June meeting and was approved. The results are developing and the first "leadership program" for staff

was sponsored by the American Medical Association during March 1967 at the Drake Hotel in Chicago. Those in attendance from all parts of the country, were invited to tour the headquarters office during the session. Members of ISMS staff acted as consultants, presenting programs.

The AMA plans a similar session for physician-leadership in the near future.

Arthur F. Goodyear, M.D., *Chairman*

EXECUTIVE ADMINISTRATOR OA-7

The executive administrator has continued to be responsible for the administrative implementation of the actions of the House of Delegates, the Board of Trustees, and the more than 60 committees of the state society. In this respect he has presented detailed reports to the Board of Trustees on his activities and the conduct of his office, especially those items relating to the functions of staff, and the financial affairs of the society.

In recent months a major change in the staffing pattern has been made. In view of the overwhelming problems in the economic areas of medicine related to such things as Medicare and Title XIX, along with negotiations with the Department of Public Aid, it was found to be substantially evident that improved communications with members regarding these problems would be helpful. Therefore, the committees dealing primarily with the economic functions were recently assigned to the Director of Public Relations with the understanding that he would initiate additional communication projects to keep the members up-to-date. Although this change in administrative assignments has been in effect only three months, the material prepared for the journal, newsletter, and other special mailings to the membership have been especially well done.

Other areas of administrative action are currently being considered by the special Task Force to Study the Opinion Research Survey. The report of the chairman of that task force has been submitted to the House of Delegates. The subcommittees have been meeting, and it is expected that recommendations will be made to the House of Delegates based upon their efforts and findings. In my opinion, the future activities of the society, and the direction which will take place with respect to the services to the members will be largely determined by the thoughtful recommendations of this task force. My principle regret is that I will not be the executive administrator of the society when the recommendations are made by the task force, and I will not have an opportunity to implement their suggestions.

I have submitted my resignation to the society effective Feb. 10, 1967, at the time of preparing these comments. The past almost seven years have been pleasant and challenging. My special thanks to a fine staff which has always supported and carried out our administrative objectives. I am certain my

successor will continue to provide guidance to the staff and pursue a course of action as enunciated by the Board of Trustees founded on the policies of the House of Delegates. If I, in my new capacity as President of the National Confectioners Association, located in Chicago, can ever be of further service to the Illinois State Medical Society, I will consider it a compliment to be called upon.

Robert L. Richards

SPEAKER AND VICE SPEAKER OF THE HOUSE OF DELEGATES OA-8

In spite of an unusually busy agenda the House of Delegates' meeting in 1966 was characterized by a minimum of confusion. Unfortunately, the Tuesday and especially Wednesday afternoon sessions were long and the delegates showed signs of fatigue and unrest. Attempts are being made to alleviate this situation in 1967, and your speakers hope that with the cooperation of the members of the House of Delegates, officers, and staff, the sessions will be recessed at an earlier hour.

A questionnaire was mailed to each delegate regarding criticisms and suggestions for the operation of the house. A reasonable number of replies were received. Suggestions included the following: (1) Finish reference committee reports on Tuesday, regardless of an evening program schedule. (2) Clear Wednesday for elections and early adjournment in order to allow for train connections. (3) Reduce formalities and unproductive activities. (4) Continue efforts to streamline the conduct of the House. (5) Start the Wednesday afternoon session earlier than 3 p.m., changing the Camp Lecture to another time. (6) Members should be urged to confine detailed discussions to reference committee hearings rather than continue them on the floor of the House. The "verbose" should be limited to permit others to speak for the question at hand. (7) Summarize the reference committee reports as much as possible. (8) Stagger reference committee meetings. (9) Do not present resolutions that have "veiled or hidden meaning". (10) Limit acceptance of resolutions to "prior to meeting" unless accepted by unanimous consent of the House. A suggestion was made that the definition of "prior to meeting" would be at least 24 hours before convening of the first session of the House. Another suggestion was made that a resolution must be submitted 30 days before the meeting. (11) An earlier start for reference committee hearings allowing for earlier adjournment. (12) Have reference committee reports available several hours before the House convenes to consider these reports.

Your speakers hope to recess the Sunday afternoon session at 5 p.m. and start reference committee hearings at 7 p.m. It is also hoped to adjourn the House of Delegates meeting by 5 p.m. Wednesday. In 1966, there were two lengthy reports on the Sunday afternoon agenda which will not be heard this year. These included the review of the Opinion Research Survey and a presentation re-

garding the proposed AMA dues increase. Your speakers hope to adjourn the House of Delegates by 5 p.m. on Wednesday. The Wednesday session will convene at 2 p.m. since arrangements have been made to hold the Camp Lecture at a time when the House of Delegates is not in session.

The Bylaws of the ISMS state that elections must be the first order of business on the last day of the meeting. The next order of business should be the consideration of reference committee reports not considered on the preceding day. It is the opinion of the speakers that the consideration of the reference committee reports is the most important matter coming before the House of Delegates and that these should not be delayed until late afternoon of the last session. However, the presentation of the reference committee reports on Wednesday afternoon might be interrupted for the induction of the president. This is advisable since a definite time should be determined for this formality. This is done as a courtesy and convenience to the press, photographers, and honored guests. Other items on the usual agenda for the Wednesday afternoon session will be presented following the elections, the induction of the president and consideration of the reference committee reports.

During the 1966 meeting, the reference committees handled their work in a very efficient manner. Their reports were completed in adequate time to allow staff sufficient time for duplicating the reports for distribution at the opening of the Tuesday afternoon session. An attempt will be made in 1967 to have the reports available in advance of the House of Delegates session allowing the delegates time to consider and discuss these reports before they are considered on the floor of the House.

Following a change in the Bylaws in 1966, we will not be restricted to the number and name of the working reference committees other than the Reference Committee on Amendments to Constitution and Bylaws. This will provide a better distribution of material and work load. An additional committee is being appointed this year to consider the Opinion Research Survey. This material was presented in part at the 1966 meeting. An article reviewing the survey was published in the January, 1967 issue of the *Illinois Medical Journal*. Every member of the House of Delegates will receive a copy of the survey before the House of Delegates meets in May and should be familiar with the report. The task force to study the survey expects to have a progress report available prior to the meeting of the House of Delegates. Your speakers believe that this is such an important matter that the reference committee reviewing the survey should consider no other business and should meet at a time when no other committee is in session. This hearing will be held on Monday morning. All members of the House of Delegates are urged to attend.

The reference committees have been appointed following consultation with the officers and trustees and will be published in the April issue of the *Illinois*

Medical Journal. We have attempted as wide a geographic distribution as possible and also considered the preferences expressed by delegates responding to the questionnaire. Early appointment was possible due to the change in the Bylaws requiring that all delegates be elected by Dec. 31 of the preceding year. It is extremely important that all reference committee members be present at the time the reference committee hearing convenes. Each year a few reference committee members fail to appear and it is extremely difficult to find a replacement at that time.

It is planned to continue the meeting of trustees with delegates from their district before the House convenes on Sunday afternoon. This proved very successful last year, allowing a review of resolutions and other business to come before the House.

The permanent handbook revised and published in 1966 will again be distributed to delegates this year. Many favorable comments have been received regarding the handbook. It has been well received on a national level and we have had many requests for copies from other state societies.

The general format of the House of Delegates' meeting in 1967 will be similar to that in 1966. The Sunday session will convene at 3 p.m., Tuesday and Wednesday at 2 p.m. All reference committee hearings will convene at 7 p.m. Sunday with the exception of the committee to review the survey. This hearing will be held at 9 a.m. Monday. It is hoped that as many reference committee reports as possible will be considered before the House recesses at 6 p.m. on Tuesday. The usual buffet for delegates and their wives is planned for Sunday evening between recessing of the House and the reference committee hearings.

Your speakers throughout the past three years have constantly reviewed the operations of the House of Delegates in an effort to improve its efficiency and effectiveness. Changes have been made which we hope have met with your approval.

Edward W. Cannady, *Speaker*
Maurice M. Hoeltgen, *Vice Speaker*

PRESIDENT OF THE WOMAN'S AUXILIARY OA-9

As president of the Woman's Auxiliary to the Illinois State Medical Society it is an honor to report on our activities during this past year. It is with pride that we call attention to the effective work going on within the county auxiliaries by the individual members. Our state chairmen have been most diligent in carrying out their assignments and the enthusiasm for the auxiliary among the councilors, directors, and state officers has been most gratifying. We urge you to read the reports of our various accomplishments in the auxiliary handbook for delegates.

We have appreciated the invitation to have auxiliary representation on some of the state society committees. Whenever the committee has suggested

our active participation, we have been happy to cooperate. As a result of one request, an ad hoc committee on medicine and religion was named for the auxiliary.

Auxiliary representation on the state society committees of legislation and public affairs has been particularly fruitful. A highlight of our year was our participation with the medical society in its Public Affairs Round-Up in Washington, D. C. At the same time, we were privileged to attend the National Chamber's 5th Association Public Affairs Conference.

Benevolence in the Illinois State Medical Society is a real and humanitarian function and the auxiliary is proud to be a part of it by continuing to support the fund. This year we note an increased interest in both the Benevolence Fund and in AM-ERF. The auxiliary has worked hard to raise substantial contributions for both these worthwhile endeavors.

We are grateful to the state society for the space allotted to us in the monthly newsletter, "Pulse". We feel that through the pages of "Pulse of the Doctor's Wife," we can reach all the doctors and their wives in Illinois and inform them of our activities and accomplishments.

The Illinois State Medical Society House of Delegates endorsed the AMA-sponsored joint membership project last May. Twelve counties have adopted the dual membership plan. Through you, the members of the state society, we invite your wives to join us, either as members-at-large or as members of organized county auxiliaries. To meet the challenging problems of medicine today and tomorrow, we need every eligible doctor's wife in Illinois a member of the auxiliary.

Much to our disappointment no new county auxiliaries have been organized this year. Here is an area where we especially need the support and cooperation of the members of the county medical societies where there are no organized auxiliaries. Strength flows upward from the county auxiliaries to the state auxiliary and it is the county auxiliary and its members who accomplish our objectives with action.

Service to our communities, by being leaders in their health projects, has long been an important phase of our auxiliary program. Working either as an individual volunteer or through the auxiliary, the doctor's wife is uniquely qualified to lend support to worthwhile community-sponsored health activities. This year the national auxiliary simplified and focused its program, coordinating the role of the community service committee to undertake one health education project: "Health of the School Age Children and Youth." By using one of the national auxiliary's new package programs, we have tried to bring an urgent community health need to the attention of its public. The committees of mental health, rural health, safety and disaster preparedness, and health careers have all been involved in this overall program.

At the other end of the age spectrum the aux-

iliary, through its Committee on Aging, has continued to show concern for the elderly through varied and interesting direct service projects.

A new undertaking on which we have made a start this year is the placement of the "AMA Health Education Service for Schools and Colleges" newsletter in secondary schools and colleges. This is a tremendous opportunity, not only for organized auxiliaries but also for members-at-large, to provide authentic health information to the schools in our communities.

The critical elections last fall, of course, sparked new interest among our members in the affairs of government at local, state, and national levels. Under the guidance of the legislation and public affairs committees, auxiliary members will continue to educate themselves about politics and educate the public about the medical profession.

We have also shown our interest in International Health Activities by collecting and shipping needed medicinal samples and supplies overseas. This year we have supplemented these activities by entertaining foreign doctors, their wives, and their families and also international students who are living in our communities.

The auxiliary actively supports the WA-SAMA groups in our state. In Illinois there are now four chapters. As these young women will be our future auxiliary members, we feel that personal friendly interest in their groups and financial contributions from our auxiliary is a most rewarding project. The auxiliary has given the National WA-SAMA \$500 for their tenth annual convention to be held in Chicago this May.

As president it was a privilege to attend all the district meetings and participate in their programs. Although these meetings for the most part were well planned, attendance, with a few exceptions, was very disappointing. These district meetings are worthy of careful evaluation and a continued effort toward improvement should be made. Perhaps, through the joint endeavor of the trustees, the counselor, and the organized auxiliaries in each district,

these meetings can again carry out their original intent of presenting, through stimulating workshops, an overall picture of the extensive and varied activities which the auxiliary offers to its membership.

The Woman's Auxiliary to the Illinois State Medical Society is grateful to the executive administrator, his associates, and his staff for their efficient services and their genuine concern in fulfilling our needs and requests. The opportunity to serve as auxiliary president has been a challenge that could not have been met without the wise and patient counseling of the advisory committee and the continued encouragement of the members of the state society. We consider it a privilege and a pleasure to work for you and with you.

Mrs. Newton DuPuy, *President*

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY OA-10

We are all proud of our auxiliary and we commend them for their dedication and for the scope of their endeavors. We note with justifiable pride their efforts in the field of community service, which includes mental health, safety and disaster preparedness, rural health, para-medical recruiting, and aging. Their continuing interest in legislation and public affairs, in International Health Activities, and in the WA-SAMA groups is appreciated. Finally, we are sincerely grateful for their contribution to Benevolence and AMA-ERF. We note that 12 of the 41 counties now have joint membership. In the past year we have been happy to see in the monthly issue of the *Pulse* a proper recognition of the activities of The Woman's Auxiliary to the Illinois State Medical Society. Assuredly, our auxiliary plays an important part in helping us to carry out our purposes. We accord them first place among the 50 state auxiliaries.

Caesar Portes Arthur E. Goodyear
Newton DuPuy, *Chairman*

THE POLICY COMMITTEE OA-11

The Policy Committee has prepared for the consideration of the House of Delegates statements pertaining to many and rather varied subjects. New policy appears in italics, and upon these subjects, the reference committee should make recommendations for House action.

A definition of "policy" was approved for the consideration of the House, and it appears this year as the preface of the Manual itself.

William E. Adams, *Chairman*

Paul P. Youngberg

Frank J. Jirka

Policy Manual of the Illinois State Medical Society

May 1966

PREFACE

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and By-laws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

- (1) approve, amend, or reject
- (2) refer the statement to the Board for reconsideration and subsequent report—
- (3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House may appear as a portion of the annual report of the Policy Committee, or they may be contained in other reports to the House. The final statements for publication in this Policy Manual are to be prepared by the Policy Committee. Any member of the Illinois State Medical Society may submit a policy statement for consideration.

Temporary policy between meetings of the House, is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois, and the Society must recognize such policy until it has been changed at the national level.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by

the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic processes.

Assessments and/or Dues

Voluntary assessments and/or contributions may be solicited from dues-exempt members of ISMS.

Assessments, Compulsory

It is not proper to condition hospital medical staff membership on compulsory assessments for any purpose.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Autonomy of County Medical Societies

No ruling of any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association, or with the Constitution and Bylaws of the Illinois State Medical Society.

In all other areas, the county society shall be autonomous.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees of the Board. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to

provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities.

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public.

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Discrimination

See "Freedom of Choice"

Dues, Recommendation of the Board to the House

The Chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration at the spring meeting of the Board.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the Illinois Medical Journal as a part of the annual report of the Chairman of the Board.

Education

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees.

Individuals covered by various fee schedules shall

receive the best type medical care in all cases, and the physicians involved shall be remunerated according to the accepted fee schedule. Fees should be commensurate with services rendered.

Financial Policies (also see "Assessments," etc.)

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees; however, such recommendations must be approved by the Board.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, etc., and any other area which involves the health of the residents of this State.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

Hospital Assessments—See Assessments

Hospital Records and Their Availability

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when needed, to insurance companies, governmental agencies, consulting physicians, etc.

Hospital Staff Privileges

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

Immunization Program

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Insurance Plans

Physicians are urged to cooperate with voluntary health insurance plans approved by the Illinois State Medical Society.

Senior citizens who are covered under these approved policies should be served at appropriate adjusted charges.

Insurance programs for the membership of the Illinois State Medical Society should be studied and implemented by the proper committee. Major medical and comprehensive hospital group coverage should be part of this insurance package.

Journal Publication

The Journal Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the Illinois Medical Journal.

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Lay Employees and Their Prerogatives

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

change existing policy

establish new policy

request House approval of committee

projects and/or

procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Legislative Committee for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Legislative Committee of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Legislative Committee, which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Legislative Committee should primarily consider relationship of the proposed legislation to the total legislative program.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

Membership in the Illinois Association of the Professions is encouraged. Medicine should be well represented among these allied professional groups and the growth and development of the Association is of concern to ISMS economically, politically and scientifically.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Mental Health

Mental health planning should be implemented at the community level. County medical societies should be kept aware of their responsibilities to assist in developing improved mental health facilities.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of all physicians involved in industrial work.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physical assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Policy Statements

Policy statements shall be defined as guide lines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

Polls, Opinion

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion HAS BEEN expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Press

All county medical societies should cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Publication of Research Data

In releasing research material to the press for publication in the Illinois Medical Journal, or any other media, extreme care should be exercised. The

welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state society advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be checked and adjusted in a fair and equitable manner.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Equality of payment to private physicians who serve the medical needs of recipients of public aid should prevail throughout the State.

Residents of Illinois eligible for medical care through the State Department of Public Aid programs should have the necessary services available regardless of the county in which they reside.

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Reference Committee Appointments

The speaker of the House of Delegates shall appoint to the reference committee considering finances and budgets (whenever practical) at least two members who served on this committee at the last annual meeting.

(This previous experience and knowledge concerning the budget, the financial statements, etc., of these members will be a distinct advantage to this committee in the preparation of its report to the House of Delegates.)

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately

be referred to the secretary of the county medical society involved.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon the recommendation of the committee with the approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

Stationery, Use of Official

No officer, trustee, committee chairman or staff

director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

Woman's Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

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COMMITTEE TO STUDY COMMITTEES OA-12

This committee has met at the time of every meeting of the Board of Trustees since the 1966 annual meeting.

The material approved by the House of Delegates at the session last May included recommendations contained in the report of the committee published in the Handbook for Delegates, and also in the supplementary report submitted by the committee at the time the reference committee was in session.

To refresh your memory on these actions of the 1966 House, the Committee to Study Committees, together with the Constitution and Bylaws Committee, was authorized to develop for the consideration of the 1967 House of Delegates, changes in the Bylaws to accomplish several recommendations, some of which were:

1. List and define the committees composed of board members and appointed by the Chairman of the Board.
2. Establish a ruling whereby committee appointments will give only one committee appointment to an individual physician. However, he may also serve as an ex-officio member, a resource consultant, etc.
3. Develop a list of interested physicians in the headquarters office from which appointments and/or replacements may be named. (This has been done during the past year, and the names are on file in headquarters office.)
4. In the appointment of committee personnel (involving some 65 committees and a total of perhaps 300 physicians) the over all representation from each trustee district should be based upon the number of physicians in each district.
5. Committees should be appointed on an annual basis to make it possible to discharge inactive committees without a change in the Bylaws; to enlarge committee membership; to replace inactive personnel; to combine committees, and to eliminate dual membership.

The Committee to Study Committees has not met with the Committee on Constitution and Bylaws to date. It is possible that the report of this committee might constitute a joint report of the two committees in the area pertaining to the committee structure. It is also possible that the Committee to Study Committees might file a supplementary report to keep the members of the House informed of any new work under construction.

The activities of the committee include a continued study of the responsibilities of each committee; the possibility of combining committees working in approximately the same area, and making such recommendations to the board for consideration.

William H. Schowengerdt, *Chairman*
Joseph R. O'Donnell Darrell H. Trumpe
Ted LeBoy Charles K. Wells

ETHICAL RELATIONS COMMITTEE OA-13

The primary function of the Ethical Relations Committee is to serve as an appellate body to review cases of alleged misconduct referred to it by component societies or appealed by individual physicians. During the past year, the committee sat in judgment of appeals from three physicians.

On Oct. 16, 1966, the committee reviewed the appeal of a Chicago physician who had been expelled from the Chicago Medical Society for unethical conduct. A study of the county medical society's transcript revealed an error in procedure and the case was referred back to the Chicago Medical Society for rehearing.

On Jan. 15, 1967, the committee sustained the actions of the Chicago Medical Society involving two physicians, one censured and one suspended. At the time of this report, neither physician had appealed to the American Medical Association.

Weber Medical Clinic

In an unprecedented case last summer, the Eighth District Ethical Relations Committee investigated the Weber Medical Clinic physicians of Olney, for alleged charges of unethical conduct. The charges—filed by the Illinois Pharmaceutical Association—alleged that the physicians had exploited their patients by forcing them to purchase their drugs from the clinic-owned pharmacy.

Following an intensive, exhaustive investigation of the clinic's practices, however, the District Ethical Relations Committee found the Pharmaceutical Association's charges to be unfounded and unwarranted. The ISMS Board of Trustees concurred in the decision.

Not only did ISMS clear the physicians of all alleged charges, but it commended them for their highly ethical practices and devoted service to the community.

ISMS Supports Weber Clinic

Since the Pharmaceutical Association's charges against the clinic physicians were published nationwide in the June 24, 1966, issue of LIFE magazine, the committee recommended that ISMS stage an all-out public relations campaign to clear the physicians.

It did so by publishing stories in the ISMS *Pulse* newsletter, the *Illinois Medical Journal*, and sending press releases to over 300 Southern Illinois newspapers. Stories were also published in the *AMA News*, *Chicago Medicine* and at least 12 other professional publications.

Dr. Willard Scrivner, Ethical Relations Committee Chairman, and ISMS President Dr. Caesar Portes appeared on radio and television refuting the charges brought against the Weber Clinic physicians. The committee feels that this public information program—showing the willingness of the medical profession to investigate questionable medical procedures—proved to be one of the most successful public relations projects undertaken by the society.

Six Downstate Cases

The committee also conducted its annual survey of county medical societies regarding the disposition of ethical relations cases on the local level. The survey—which drew responses from 41 counties—showed that six other disputes were heard during the past year.

Two of these cases involved excessive fees and were settled through agreements between the physicians and their patients. Two cases of unprofessional conduct were settled by the county medical society committees. A case concerning the use of bank credit cards received assistance from ISMS and the American Medical Association, while a case involving the professional capability of a physician remains unsettled. All these cases remained at the county level.

This does not reflect the entire story, however, since the Chicago Medical Society actually has three different committees screening the complaints which otherwise might come before and be reported to our Ethical Relations Committee. Only those cases warranting the attention of the Ethical Relations Committee are referred to it, while others are disposed of by other committees.

In recognition of the several forces including government involvement, consumer trends, and technological progress, the committee anticipates diverse areas which will require clarification in matters of medical service to the public. We must also consider organized medicine's plans and implementations to sustain and insure the high standard of present day medical care.

Willard C. Scrivner, *Chairman*

J. Ernest Breed
William M. Lees

Burtis E. Montgomery
J. Mather Pfeiffenberger

COMMITTEE TO STUDY DISTRICT ADMINISTRATIVE OFFICES OA-14

The Committee to Study District Administrative Offices was appointed by the Board of Trustees as a direct result of Resolution 66-45, submitted by the Peoria Medical Society, and Resolution 66-19, submitted by the Will-Grundy County Medical Society at the 1966 meeting of the House of Delegates.

The committee met on Nov. 5-6, 1966, and Jan. 21-22, 1967. It reviewed the materials submitted by the Peoria Medical Society, and the Will-Grundy County Medical Society supporting their resolutions. It also reviewed the organization of medicine; the changing role of the state medical society, and the progress of county medical societies presently being served by full-time executive secretaries.

In light of the information submitted, the following objectives were determined:

To study, research and make recommendations to the Board of Trustees which may materially assist the already established administrative units of medicine, and

Also lead to the establishment of additional administrative units of organized medicine designed to

more adequately meet the needs of the profession, and

To study, research and make recommendations regarding the financing mechanisms which may be employed in order to more adequately maintain present administrative units of organization, as well as in the establishment of additional administrative units.

NOTE: The administrative unit of organization referred to in the objectives must be able to provide certain services and advantages over the presently existing structure of organization. They may be outlined as follows:

1. Manage effectively area groupings of the profession on a business-like basis.

2. Earn the respect and loyalty of the individual physician for the particular unit of organization.

3. Promote the image of the medical profession, and constantly relate to the public the significant progress of medicine.

4. Involve and increase the desire of physicians to participate in activities relating to economics, public affairs, etc.

5. Achieve substantial area agreement on solutions to problems which may be recommended to the state medical society and thereby provide an adequate mechanism for the development of policies from the grass-roots.

6. Maintain continuity of management and formal medical policies between organized medicine, the public and governmental agencies.

7. Demonstrate through action and possibly pilot programs what further services may be found useful to the profession if rendered through such a unit of organization.

In preparation for further investigation and study, the chairman appointed two subcommittees, one to give attention to the organization of district administrative offices, and the other to give attention to the methods of financing district administrative offices. The chairmen of these subcommittees respectively are: Thomas P. deGraffenried, M.D., and Alfred J. Faber, M.D.

At the second meeting of the committee, the subcommittees met and discussed their various assignments. The minutes of these subcommittee meetings are available. Upon presentation to the full committee, the conclusions reached, and of primary importance are set forth as follows:

1. This committee will try to meet again before the 1967 meeting of the House of Delegates to review additional information. At the present time it would appear as though this committee should be continued by the House of Delegates to continue its study.

Therefore, we so recommend.

2. Three members of the committee, Doctors Houk, Shaw, and Becker have been asked to prepare a written statement on the 10 most valuable services rendered to their membership by the executive office of their societies of McLean, Cook, and Will-Grundy counties. An additional paper is to be prepared on what services might be rendered

by a full-time executive secretary-at-large working for a number of small medical societies.

3. The chairman of the committee has been invited to attend meetings of the AMA, and to inquire into what management, or business consultants, might be used in determining the future course of county medical society business services. This applies particularly to the area of computerization, financing of medical care, etc.

4. Several members of the committee have been asked to contact officers of their medical societies to determine their interest in the possibility of a demonstration project. These are areas not presently being served by full-time executives, and it is believed possible to initiate demonstration projects within the next year. Demonstration projects would be supported by dues as well as grants from foundations, industry, the AMA, the state society, etc. Additionally, the committee is exploring the expansion of presently established full-time executive offices. This is especially true in the areas of the Will-Grundy and Winnebago County Medical Societies. The purpose here is to determine whether or not county medical societies surrounding these particular areas are sufficiently interested and willing to support financially, as well as organizationally, the expanded services of the presently constituted executive secretary.

5. The committee recommends that it be authorized to explore with the health department and other state agencies their plans with respect to "Planning for Future Health Care Services." Authorization has been made by the U. S. Congress which provides for funds not only for planning of medical care services, but also for the implementation of that planning. We believe the state medical society should assume an active role in this planning.

At the same time, the subcommittee on organization expects to continue to study the philosophy of "Medical Service Areas." This study will include contacts with the Illinois Hospital Association, the Illinois Dental Association, the Illinois Nurses Association, and other groups which would be involved if medical services were to be organized on an area-wide basis, rather than by county societies.

6. The committee in the future will make a thorough study and analysis of the functions it believes best performed at the various levels of organized medicine. It is realized that there is duplication of services. We believe it is possible to differentiate those services best performed by county societies, those best performed by the state society, and those best performed by the AMA. As soon as this document is prepared we hope to present it to the Board of Trustees, and if possible, in a supplementary report to the House of Delegates.

7. The committee in final consideration of Resolution 66-45 submitted by the Peoria Medical Society which recommended a refund of state society dues to county societies with full-time executive secretaries, recommends that the resolution as constituted *not be adopted*. The committee believes that this resolution would not solve the basic financial

problems of county medical societies, and that a refund of ISMS dues to county societies would only serve to weaken the financial position of the state society. Finally, this committee, as presently constituted, is currently working on other alternatives which may prove to be more attractive and acceptable to all concerned.

8. With respect to Resolution 66-19 introduced by the Will-Grundy County Medical Society which concerned itself with the establishment of district offices, we believe this resolution is presently being implemented by this committee.

We trust that the House of Delegates will feel that we have made significant progress after consideration of this report along with any other supplementary information which may be submitted prior to the May 1967 meeting of the House of Delegates.

Robert J. Becker, *Chairman*

C. Elliott Bell	Preston S. Houk
Willis W. Bowers	Charles A. Lang
Charles U. Culmer	David B. Lewis
Thomas P. deGraffenried	Joseph A. Petrazio
Alfred J. Faber	Noel Shaw
Robert E. Heerens	H. E. Wachter
	C. H. Walton

EX OFFICIO:

Robert Best, *Executive Director*, Will-Grundy County Medical Society
Gene Conrad, *Executive Secretary*, St. Clair County Medical Society
David W. Meister, *Executive Secretary*, Peoria Medical Society
John W. Neal, *Executive Administrator*, Chicago Medical Society
Mrs. Julia P. Schulz, *Executive Secretary*, Lake County Medical Society
Donald A. Westbrook, *Executive Administrator*, Winnebago County Medical Society
Mrs. Lillian Widmer, *Corresponding Secretary*, DuPage County Medical Society

MEMBERSHIP COMMITTEE OA-15

The ISMS Committee on Membership exists on an advisory basis to serve the county medical societies that request assistance in matters of medical society membership. Since the ISMS Bylaws state that the county society shall be sole judge of the qualifications of a physician for membership in ISMS or the AMA through Illinois, the Membership Committee does not have the primary responsibility for increasing the membership of our society.

There has been no request for assistance of the committee since the last meeting of the House of Delegates. Accordingly, no formal meeting of the Membership Committee has been handled by the staff and the ISMS Secretary-Treasurer, on the basis of previous policies. In this connection, the reader of this report is referred to the report of the Secretary-Treasurer for further information regarding ISMS membership statistics.

The importance of developing programming and committee activity directed toward the needs and problems of the physician in full-time teaching, administration or other activities is indicated by statistics regarding the number of physicians doing little or no private practice who do not feel it necessary or desirable to belong to their state and county societies. Program materials directed along these lines may be developed and additional assistance can be provided by the society's staff if it is desired by the county medical societies.

Joseph O'Malley, *Chairman*

Harold E. Himwich

Roger Hoekstra

Fritz Koenig

Clarence Norberg

H. D. Scott, Jr.

AMA DELEGATION OA-16

The delegation from the Illinois State Medical Society to the American Medical Association closed a successful year, due primarily to the close-knit, well informed and smooth functioning procedures developed during recent years.

The outstanding accomplishments of the ISMS included the election of Dr. Walter C. Bornemeier as speaker of the AMA House of Delegates and Dr. Burtis E. Montgomery as a member of the AMA Board of Trustees to follow Dr. Percy E. Hopkins, who retired.

The delegation budget is carefully screened, first class air travel has been cut to coach, \$30 per diem is paid for six days at the June annual convention and for five days at the clinical session in November. Out of this \$30 the delegate and alternate must pay hotel, food and incidentals. It costs each one of the representatives of the Illinois State Medical Society a considerable amount from his own pocket to attend either or both of these sessions. No member of the delegation feels that criticism should be aimed at the group, and the only problem is one of explaining to the membership the expenditure of funds by the delegation.

American Medical Association headquarters are in Chicago. Illinois physicians serve on many councils, committees and editorial boards. They participate in the scientific program in the presentation of papers and the presentation of scientific exhibits. They have been the recipients of various awards, including the Distinguished Service Award given by the vote of the House of Delegates. The five medical schools and the complex of excellent teaching hospitals offer scientific participation of an outstanding nature. This area as well as the political side of medicine, is the concern of the men representing the ISMS.

Annual Meeting in June

At the June session held in Chicago, Dr. Hopkins was honored as the retiring chairman of the AMA Board of Trustees; the 22nd Conference of Presidents and other officers of state societies met with Dr. Bornemeier as its president; Dr. Warren H. Cole was given the Distinguished Service Award.

His name was added to the list of Illinois physicians who have been so elected—James B. Herrick, Ludwig Hektoen, Anton J. Carlson, Isaac A. Abt and Lester Dragstadt.

Dr. E. H. Christopherson of Evanston received the 1966 Abraham Jacobi Award.

Several Illinois physicians were honored by the American Physicians' Art Association.

In the elections held by the sections—Charles Branch of Peoria serves the Section on General Surgery as chairman; Paul H. Holinger, delegate from the Section on Otology, Rhinology and Laryngology; William McQuiston of Peoria, vice chairman of the Section on Anesthesiology; Arthur A. Rodriquez, chairman of the Section on Physical Medicine; Henry Holle, alternate delegate from the Section on Preventive Medicine; Maynard Shapiro, alternate delegate from the Section on General Practice; Wright R. Adams, alternate delegate from the Section on Internal Medicine and Albert A. Andrews is secretary of the Section on Diseases of the Chest.

Dr. William E. Adams is president-elect, Dr. Albert A. Andrews, treasurer, and Karl Pfeutze, assistant treasurer of the American College of Chest Physicians.

Mrs. Willard C. Scrivner of East St. Louis was elected one of the vice presidents of the AMA Auxiliary.

Illinois physicians received a fine percentage of the certificates of merit and honorable mention awards presented to the scientific exhibitors.

Also at this meeting Dr. Milford O. Rouse, the former speaker of the House, and Dr. Walter C. Bornemeier then vice speaker, held a meeting to which all speakers and vice speakers of state medical associations were invited. The ISMS House of Delegates received recognition at the national level when the handbook, "Your Role as a Delegate" was praised by Dr. Rouse, and distributed to all present.

Illinois physicians served on the following reference committees of the House:

Harlan English, chairman of the Reference Committee on Medical Education and Hospitals

H. Kenneth Scatliff, a member of the Reference Committee on Reports of Officers

Maurice M. Hoeltgen, a member of the Reference Committee on Rules and Order of Business

Arthur F. Goodyear, a member of the Reference Committee on Credentials and also a teller at the elections on Thursday June 30.

Resolutions From Illinois

Illinois presented six resolutions at the request of our own House, and the following actions were taken:

(1) AMA 66A-38: "Training and Development of Volunteer and Staff Leadership: (Introduced in ISMS by DuPage County Medical Society). Adopted and referred to the Board of Trustees for appropriate consideration.

(2) AMA 66A-39: "Ethical Classified Advertis-

ing" (Introduced in ISMS by G. L. Seitzinger for Section on Pathology) Advertising department of AMA was commended for its existing practice of screening advertisements to the extent that is practical. Resolution was not adopted.

(3) AMA 66A-40: "Establishment of FDA Supervisory Board" (Introduced in ISMS by Winnebago County Medical Society) The House referred this resolution to the Council on Drugs for further study and appropriate action.

(4) AMA 66A-41: "Youth Education" (Introduced in ISMS by Adams County Medical Society) Adopted by House action.

(5) AMA 66A-42: "Direct Billing Under Title XVIII, Part B, PL 89-97" (Introduced in ISMS as part of the report to the House of the Committee on Usual and Customary Fees) Adopted by House action.

(6) AMA 66A-43: "Approval of Increase in AMA Annual Dues for 1967" (Introduced in ISMS House by Saline-Pope-Hardin, Whiteside, St. Clair, Green and LaSalle Counties) Adopted by House action.

The Illinois delegation enjoyed excellent cooperation; our delegates, alternate delegates, officers and trustees all participated in the activities at the meeting in Chicago, and deserve appreciation and congratulations. The state society was well represented in the many fields of endeavor exemplified at a national meeting of the scope and importance of the American Medical Association.

1966 Clinical Session—Nov. 27-30

At the Las Vegas session, Allison Burdick was seated for Leo P. A. Sweeney, unable to attend the meeting, and Fred C. Endres was seated for Burtis E. Montgomery, who was elected as a member of the AMA Board of Trustees in June, 1966.

Illinois introduced two resolutions:

(1) C66-18—Requesting that the AMA Board of Trustees authorize a study of the feasibility of installment payment of society dues. There was no active support for this suggestion, but since there may be a few isolated hardship cases in which some adjustment of dues payment requirements might be warranted, the Board of Trustees was asked to give consideration to some limited adjustment. The resolution was referred to the board.

(2) C66-51—"Utilization Standards in Tax Sup-

ported and Private Hospitals." The resolution asked "that tax supported hospitals and private hospitals be governed by the same utilization standards". After amending the first "whereas" to read: "Whereas there is a definite need for utilization committees" the House adopted the resolution as amended.

Membership on reference committees held by Illinois physicians at the clinical session was as follows: William K. Ford, a member of the reference committee hearing reports on legislation; H. Close Hesseltine, a member of the committee receiving the reports of the Board of Trustees; Edward W. Cannady, chairman of the reference committee on miscellaneous business.

Illinois was given recognition for IMPAC activities, and Dr. Frank Coleman, chairman of AMPAC appeared before the Illinois delegation at breakfast on Tuesday morning, and spoke on the excellent cooperation secured from Illinois.

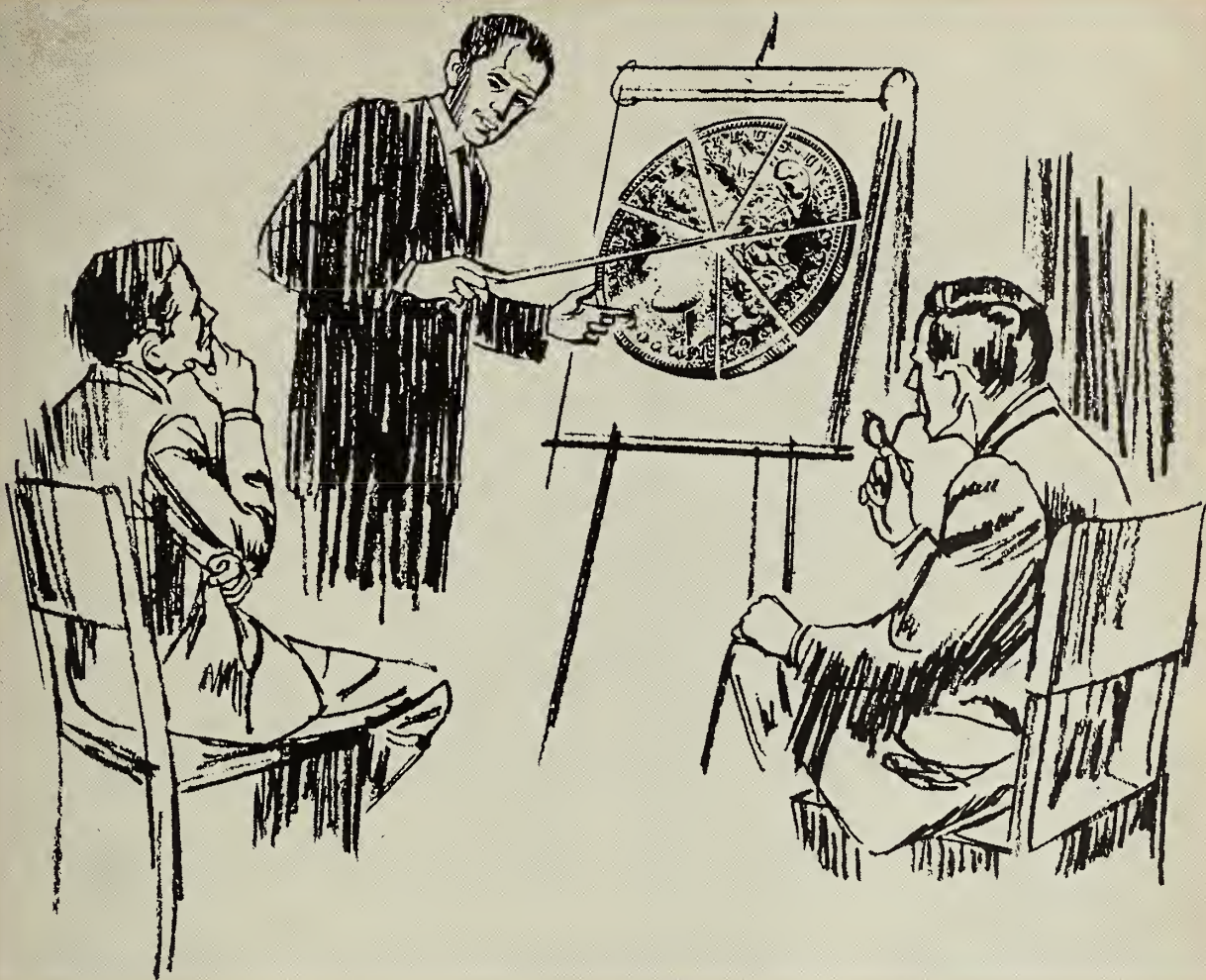
Illinois supported the action taken by the AMA Board of Trustees which requested that the action of the June House of Delegates in adopting Resolution 66A-104 be rescinded. In the report of the Board of Trustees to the House, the recapitulation was presented, including the basis for the board action. The board had been informed by legal counsel that the possible economic effects of the resolution passed in June, were of concern to the Department of Justice. Implementation of the resolution either at the state or county level, might involve significant legal risks.

The gist of Resolution #104 was:

"That, since separate billing by the physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing".

New officers for the delegation were elected at the last meeting, and a special vote of appreciation given to Dr. Cannady for the work he had done with and for the delegation during the past two years.

Maurice M. Hoeltgen, *Chairman*
William K. Ford, *Secretary*



Finances and Budgets

SECRETARY-TREASURER FB-1

"Perfection in the conduct of government has thus far been achieved only in Heaven. I expect that this will continue to be the case in the future." Robert F. Wagner, the most recent ex-mayor of New York City, spoke these words in describing the administrative problems of giant cities, but they might easily be applied to today's medical organizations. Although we may strive mightily for final solutions to all areas of involvement, the sunny glow of complete success is usually clouded over by persistent frustration in seeking solutions of new problems as well as the solving of old ones. In the rapidly changing medical environment of recent years, this is no small field of activity.

Development of survey data on usual and customary fees (to protect ISMS members' socioeconomic status), research into the possibility of

district administrative offices, implementation of study of the opinion research survey, major staff re-organization and many, many other matters have had to be worked into the already overloaded work schedule of ISMS officers and staff. With no 1966-67 increase in personnel, we have attempted to handle last year's program, this year's additional needs and still advance the deserved reputation for ISMS progressive leadership that has been attained among all other state medical societies.

Administrative Staff

The 1966-67 fiscal year has been one beset with major administrative frustrations. Chief among these was the announcement by Mr. Robert L. Richards on Dec. 10 that he was submitting his resignation as Executive Administrator to become President of the National Confectioners Association. An ad hoc committee (consisting of past presidents of the society) was appointed on Dec. 15 by the

Executive Committee meeting in special session, to seek, interview and recommend to the Board of Trustees a successor to Mr. Richards. On Jan. 14, 1967, this committee recommended the employment of Dr. George F. Lull (who had served the society as Secretary-Treasurer for approximately one year following the death of Dr. Harold M. Camp) as interim Executive Administrator until the committee could conduct an adequate investigation for filling this position on a permanent basis. This action was approved by the Board of Trustees.

Several other changes in staff have taken place during the year in the manner of resignations and replacements, changes in assignment of responsibilities and duties and voids left by prolonged illnesses. Added during this turmoil has been the need for the implementation of special and unforeseen activities.

Despite such upsets, the staff directors and their assistants have functioned efficiently and well. No programs or projects have had to be curtailed or sacrificed. All departments have functioned effectively.

Such efficiency and capabilities bear double commendations; first, to the entire staff for their adaptability to unexpected emergencies and their ability to cope with them, and second, to Mr. Richards who, during his seven years with the society, so ably established and developed an organizational set-up capable of meeting such challenges.

House of Delegates Minutes

A complete stenographic record of the 1966 House of Delegates session is available to any interested member of the society at the society's office upon request to the Secretary-Treasurer or the Executive Administrator.

In order to make the major actions of the 1966 House immediately known to all members of the society, a resume was mailed to each delegate within one week after the meeting. This enabled delegates to report promptly to their local societies. An abstract of the 1966 stenographic minutes was also provided the delegates about three weeks following the conclusion of the meeting. The June, 1966, issue of the *Illinois Medical Journal* contained this same abstract for the benefit of each member.

To emphasize actual results and to avoid further demands upon the time of the House, in 1967 the abstract form of the minutes will be acted upon (as in the past) as the official minutes of the 1966 session.

Follow-up on directives and assignments by the 1966 House have been implemented by the Board of Trustees and staff throughout the year. The Executive Administrator and staff develop a log of action and devote a substantial share of their time and efforts each year to accomplish such directives. Each individual staff member is assigned the responsibility for achieving completion of items pertinent to his division. In every case, all requests by the House have been acted upon promptly and completely.

Communication With Members

When the Illinois legislative year of 1967 began, the entire membership received the first issue of the current session's *On the Legislative Scene*. This newsletter is produced "on the spot" in Springfield, and contains the most up-to-the-minute status for each bill affecting the practice of medicine. Because first class mail is used for this weekly publication, only members requesting to be added to the mailing list receive it. If you did not request this at the time you received issue Number 1 and want to be included, a note to the Chicago or Springfield office will accomplish this.

The *Illinois Medical Journal*, the *Pulse*, and the calendar of events, *What Goes On*, are sent monthly to each ISMS member, the latter two financed by special grants from pharmaceutical firms. From the broad-based *Illinois Medical Journal* to the specific interest *Pulse* and *What Goes On*, we seek to keep each physician a well-informed and actively-interested member. In addition, the *Secretary's Newsletter* has been sent to county secretaries at intervals.

The official minutes of each Board of Trustees meeting are sent to every county society delegate and officer in the hope that a more informed local leadership will be better able to understand and assist the complex program and needs of the state medical society. Every member is, of course, encouraged to request any information, record or report in which he might have an interest. This may be done by contacting the Chicago office or me personally.

When each member receives an item of society mail, it is essential that he realize that this *accomplishes only one-half of the communications process*. The other half, and equally, if not more important, are communications directed back to the society in the nature of reaction or response. Without this "feedback," officers and staff are handicapped in adapting and forming society programs to match members' needs. With substantial comment from the "grass roots," perfection in the conduct of our organization is brought substantially closer.

Billing Procedures

ISMS staff has attempted to develop an IBM record card to serve as a "data bank" for permanent information required each year for each member. This card was used for the first time in 1966 to provide membership dues billing information for each county society, and to collect and report the dues of those counties that desired this service.

An IBM service bureau is used to process data for ISMS, avoiding the necessity to purchase or lease equipment in the early stages of its use within the office. Although the anticipated "bugs" from the first year of operation did occur, these have been reviewed and corrected for the second year of 1967. Undoubtedly some still exist; these will receive attention and correction in 1967 and in future years, until a satisfactory system is developed. Reports required in the past are now available faster, more

accurately and with much less manual effort. New informational data regarding AMA-ERF donations, age classifications and voluntary contributions are now possible. Other categories are to be added as the system is perfected.

The potential variety of service that this electronically processed data can provide will be formulated and developed in the future, as ISMS seeks to provide more and more service of direct benefit to each member and his local society. The IBM equipment and records alone are useless; but matched with imagination and the desire to serve, they become a priceless asset. I foresee the day when the State office will be able to provide detailed information, individually or generally, with amazing speed and accuracy.

Leadership Conference

Nationally-known speakers headlined the 1966 Leadership Conference held at the Holiday Inn East in Springfield on April 27 and 28. Milford O. Rouse, M.D., then president-elect of the American Medical Association, and Morris Fishbein, M.D., editor of *Medical World News*, provided the audience of county society presidents, presidents-elect, secretaries and key committee chairmen a physician's-eye view of the national medical scene. Jim Low, then manager of the U.S. Chamber of Commerce Association Department, and J. W. Cashman, M.D., HEW Medicare official, both from Washington, D.C., lent further prestige to the panels on leadership and Medicare. Several personalized workshops dug deeper into individual questions and problems.

In 1967 a similar meeting is planned for Springfield on April 15-16. This year county society dele-

gates will also be invited to attend, along with previously invited local leadership, thereby making this a valuable pre-convention round-up. Resource personnel from the state society and the AMA are to be available to discuss individual matters of interest in the program areas of Publications, Scientific Services, Legislation, Public Affairs, Public Relations, Economics, Business Services and Administration, and, of course, Medicare.

State and county woman's auxiliary officials will meet in conjunction with the ISMS Leadership Conference and physicians' wives are invited to attend these sessions and get to see their auxiliary officers in action.

Membership Statistics

The changes in membership statistics are indicated in the accompanying table.

Increases in the number of society members are subject to the outside influences of the attractiveness of Illinois as an environment for medical practice and the general economic and population growth of the state. Membership has been increasing slightly over the past four or five years, but substantial increase must remain primarily dependent upon these external factors.

Although many medical organizations claim the time and dues of the American physician, only dedicated support from every physician to his local county society, ISMS and the AMA can avoid the splintering of influence that leads to unsound changes in the role of the physician in society. The state society must be the unified speaking voice of the physician—if—a voice is to be heard and recognized.

MEMBERSHIP STATISTICS

	1966	1965	1964	1963	1962	1961
Membership as of January 1	10,626	10,500	10,145	10,101	10,185	10,168
New Members	517	492	537	429	376	403
Reinstatements	65	43	211	59	72	186
Total added	582	535	748	488	448	589
Dropped during the year:						
Died	191	172	175	176	186	191
Moved from State	172	101	47	60	160	99
Resigned	21	28	7	6	9	15
Nonpayment	217	108	164	202	177	267
Total dropped	601	409	393	444	532	572
Membership as of December 31	10,607	10,626	10,500	10,145	10,101	10,185
Regular	9,417	9,429	9,412	9,097	9,056	9,156
Residents	250	278	230	223	254	235
Service	51	26	30	13	15	14
Emeritus	484	494	459	467	446	454
Retired	349	334	312	328	310	295
Hardship	52	45	31	17	20	20
Intern	4	20	26			11
Total	10,607	10,626	10,500	10,145	10,101	10,185

Investment of Reserves

Income from all investments amounted to \$22,135 in 1966, compared with \$15,468 in 1965 and \$15,373 in 1964. Investment return is subject to variation each year because of changes in the national money market and the timing of the Society's cash requirements. Maximum investment return from reserves and short-term cash surpluses is sought, consistent with the primary objective of minimization of risk of principal loss. A yearly comparative analysis of investment income is shown below.

Consistent with the suggestion of the 1966 Reference Committee on Administrative Activities, the Board of Trustees has transferred all ISMS reserves to separate Permanent and Contingency Reserve Funds. Beginning with the 1967 budget year, over \$15,000 of investment income will no longer be available to the Operating Fund, but will instead be re-invested as a part of the reserves. This substantial loss of previously available income has required the Finance Committee to institute strict budget controls over Society programs and expansion into any type of new activity or program is not possible without eliminating something else.

Financial Statements for 1966

Condensed financial statements are presented here for the benefit of the entire membership. The complete audit report for the year ending Dec. 31, 1966, will be distributed to each member of the House of Delegates prior to the meeting and is available for review by any member upon request to the headquarters office. Copies of the 1967 and 1968 operating budgets, as approved by the board, will also be distributed to each delegate and presented to the Reference Committee on Administrative Activities in advance of the 1967 Annual Convention.

In accordance with the wishes of the 1966 House, some members of this reference committee have been reappointed for 1967.

Dr. Philip G. Thomsen, chairman of the Finance Committee; Dr. George F. Lull, Executive Administrator; Mr. Roland I. King, Director of Business

Services, and myself, as Secretary-Treasurer, will be available at the reference committee hearings to assist in any way possible.

1966 and 1967 Budgets

The 1966 House of Delegates received a 1967 budget projection totalling \$808,600. The final 1967 budget submitted to the Board of Trustees by the ISMS Finance Committee totalled \$815,500 income and expenditure, with the additional \$6,000 resulting from increased *Illinois Medical Journal* advertising receipts and production expense now anticipated for 1967.

The 1967 House of Delegates will receive the 1966 audited budget and actual financial results, the 1967 approved budget, and the 1968 projected budget for the delegates' information and review.

The society's 1966 Operating Fund expenditures were budgeted for \$795,500 compared with \$757,130 actual expenditures for 1965. Addition of the costs of the new ISMS publication *What Goes On* (monthly calendar) were responsible for \$20,000 of this \$38,370 budgeted increase. The funds to produce this new ISMS service publication are entirely provided from a pharmaceutical firm grant and represent no dues expenditure.

Additional production costs resulting from a favorable increase in *Illinois Medical Journal* advertising revenues of \$20,000 were responsible for increased total budgeted expenditures in 1966, with no additional ISMS funds required. Other minor adjustments in budgets and staff re-assignments were made at no net change between 1966 and 1965 budgets.

A great deal of time and thought goes into each annual budget preparation. Sound professional budgeting practices are followed, with each budget category reviewed through several levels of the Society's staff and officers. Though not every program function receives all of the budget allocation that those responsible might consider to be desirable, the Finance Committee of the Board of Trustees makes recommendations on the best overall distribution of the income funds that are available. It

	1966	1965	1964	1963	1962	1961
Interest on Gov't. & Corp. bonds	\$10,353	\$ 6,481	\$ 4,110	\$ 1,679	\$ 2,667	\$ 3,081
Interest on bank savings accounts	8,537	6,762	9,365	14,037	11,735	10,016
Dividends	2,459	2,225	1,898	1,444	428	0
TOTAL	\$21,349	\$15,468	\$15,373	\$17,160	\$14,830	\$13,097

At the end of 1966, the following listing shows the reserve funds invested under the supervision of the Continental Illinois National Bank's trust department:

	Permanent Reserves		Benevolence Fund	
U. S. Government Bonds	\$ 55,949	24.6%	\$ 79,716	55.1%
Corporate Bonds	41,899	18.4%		
Investment-grade common stock	73,156	32.2%	58,835	40.7%
Bank savings accounts	56,305	24.8%	6,042	4.2%
Total	\$227,309	100.0%	\$144,593	100.0%

should be noted that 1966, 1967 and 1968 budgets do not include funds for any new projects, and should the House of Delegates direct any new programs of a major nature, an accompanying method of providing additional financing by the House will be necessary for their implementation.

A graphic breakdown of the 1967 budget of \$105 regular dues into the various departments and allocations is provided at the end of this report. Outside

sources of income have been assigned to their appropriate expense categories, and only the net cost to the individual member is indicated for the annual convention, *Illinois Medical Journal*, etc.

Any member or county society that wishes more information regarding any ISMS budgets or expenditures may obtain an ISMS officer to present this for a local medical society meeting or by visiting our headquarters office.

Jacob E. Reisch, M.D., *Secretary-Treasurer*

Illinois State Medical Society

POSITION STATEMENT—DEC. 31, 1966

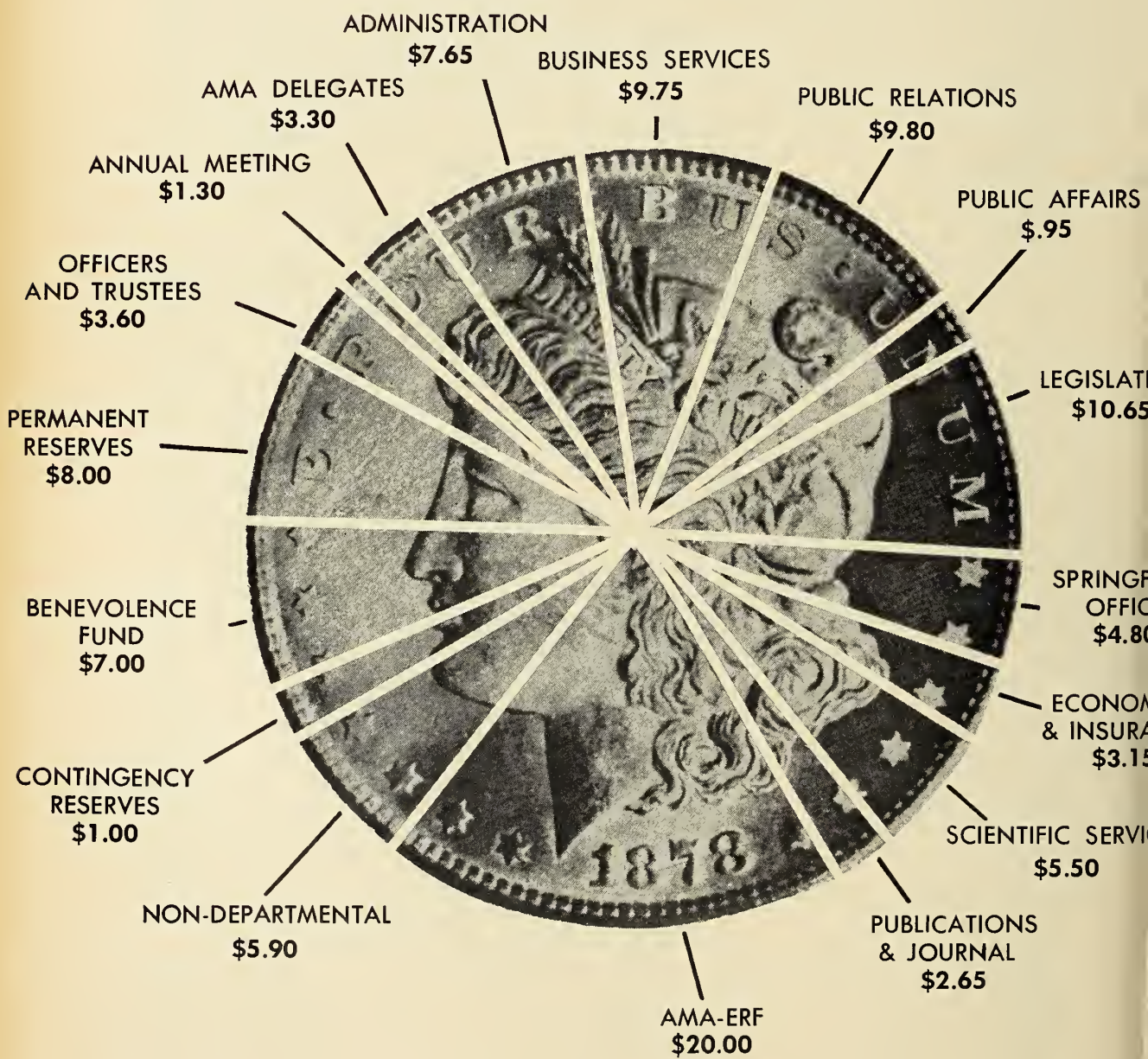
	Operating Fund	Benevo- lence Fund	Perma- nent Reserve Fund	Property Fund	Student Loan Fund	Suppl. Empl. Retire- ment Fund
ASSETS						
Cash	\$ 98,694	\$ 5,997	\$ 55,800	\$ 9,848	\$ 538	\$26,138
Receivables	27,752				1,700	
Investments, at cost		140,415	173,010		41,000	
Student loans					65,890	
Prepayments and advances	11,538					
Office furniture and fixtures				77,249		
Interfund Receivables (payables)	(44,705)	45,732		(2,027)		1,000
Total Assets	<u>\$ 93,279</u>	<u>\$192,145</u>	<u>\$228,810</u>	<u>\$85,070</u>	<u>\$109,128</u>	<u>\$27,138</u>
LIABILITIES AND FUND BALANCES						
Payables	\$ 32,760					
Accrued expenses	7,333					
Deferred income	3,858					
Fund Balances	49,328	192,145	228,810	85,070	109,128	27,138
Total Liabilities and Fund Balances	<u>\$ 93,279</u>	<u>\$192,145</u>	<u>\$228,810</u>	<u>\$85,070</u>	<u>\$109,128</u>	<u>\$27,138</u>

INCOME STATEMENT—OPERATING FUND—YEAR ENDED DEC. 31, 1966

INCOME		EXPENSES	
Membership dues—		Board and Officers	\$ 35,652
Basic dues—\$105 per member	\$995,070	ISMS Meeting	27,831
Less Allocations:		AMA Meetings	29,135
AMA-ERF—\$20 per member	189,385	Administration	73,215
Benevolence Fund—		Business Services	96,904
\$7 per member	66,285	Public Relations & Economics	93,981
Permanent Reserves—		Economics & Insurance	36,912
\$8 per member	75,706	Legislation & Public Affairs	105,939
Contingency Reserves—		Springfield Office	29,883
\$2 per member	18,926	Publications and Scientific Services	89,631
Total allocations	350,302	Illinois Medical Journal	118,931
Net membership dues	644,768	Non-Departmental	77,940
Illinois Medical Journal	101,038	TOTAL EXPENSES	815,954
“PULSE” and “WHAT GOES ON”	43,040	EXCESS OF INCOME OVER	
Annual Convention exhibits	14,569	EXPENSES	\$ 20,761
Interest & dividends	21,349		
All other	11,951		
TOTAL INCOME	<u>\$836,715</u>		

1967 DUES DOLLAR COST TO INDIVIDUAL MEMBERS OF ISM

(FIGURES BASED ON 9,450 DUES PAYING MEMBERSHIP)



TOTAL 1967 REGULAR MEMBER'S DUES: \$105.00

ILLINOIS STATE MEDICAL SOCIETY

STAFF DIVISIONS AND COMMITTEE ASSIGNMENTS

ADMINISTRATION

Constitution and Bylaws
Illinois Association of the Professions
Illinois Pharmaceutical Association—Liaison
Osteopathic Association—Liaison
to Study District Admin. Offices
to Study Opinion Research Report
Woman's Auxiliary—Advisory
Board of Trustees—
 Executive
 Finance
 Policy
 to Study Committees

BUSINESS SERVICES

Membership
Rural Health/Student Loan
Leadership Conference, Advisory

PUBLIC RELATIONS

Public Relations
Disaster Medical Care
Ethical Relations
Fifty Year Club
Grievance
Health Careers Council
Medical Assistants Association
Public Safety
Religion and Medicine
Student AMA

ECONOMICS/INSURANCE

Aging
Drug Formulary
Hospital Relations
IDPA—Advisory
Blue Cross—Liaison
Medical Economics
Prepayment Plans
Rehabilitation Services
Relative Value Study
Usual and Customary Fees

LEGISLATION/PUBLIC AFFAIRS

Legislation
Public Affairs
Archives and Museum
Benevolence
Impartial Medical Testimony
Laboratory Evaluation
Medico Legal
Narcotics
Occupational Health
Quackery

SCIENTIFIC SERVICES

Alcoholism
Cancer
Cardiovascular
Child Health
Continuing Medical Education
Editorial Board and Journal
Educational and Scientific Foundation ISMS
Environmental Health
Eye Health
Maternal Welfare
Medical Education
Mental Health
Nursing
Nutrition
Perinatal Mortality
Radiation
Scientific Assembly
Scientific Exhibits
to Study Annual Meeting
Tuberculosis
Vital Certificates

BENEVOLENCE COMMITTEE FB-2

In the calendar year 1966 the Benevolence Committee distributed 452 separate monthly payments in varying amounts to 42 qualified recipients. These payments totaled \$49,850 for the year and ranged from \$50 to \$200 per person per month. (Break-down: \$50—2 recipients; \$60—1; \$65—1; \$75—6; \$85—2; \$90—1; \$95—1; \$100—11; \$125—7; \$140—1; \$150—6; \$200—3.)

The total expenditures of \$49,850 were dispersed from 1966 Benevolence Fund income of \$78,744, for an excess of income over expenditures of \$28,894. These funds are transferred to the investment reserve account for the Benevolence Fund, to be used to develop an endowment balance that will provide most of the future annual needs out of investment income.

For January, 1967 the Committee had 38 recipients receiving \$4,370 in total each month. This current payment level will require approximately \$53,000 in the funds for the year 1967. Total income is projected at \$78,000; excess of 1967 income over expenditures, at \$25,000.

Keith H. Frankhauser, *Chairman*
Raleigh C. Oldfield John H. Steinkamp

RURAL HEALTH AND MEDICAL STUDENT LOAN FUND COMMITTEE FB-3

Attendance at State Hearing:

The committee chairman appeared before the State of Illinois Board of Higher Education Special Study Committee on Medical Manpower Problems. Hearings of this body, which is directed by James Campbell, M.D., President of Presbyterian-St. Lukes Hospital, were conducted in Chicago and Springfield. The chairman spoke in Springfield on Dec. 13, 1966. The direct relationship of health care needs throughout the state to current medical education programs and policies was stressed, including that these needs will continue to exist until there is medical school involvement in community health problems and their solutions.

Correspondence with University of Illinois Medical School Dean:

During the past year, the University of Illinois has expressed a growing reluctance to continue to accept Loan Fund Committee recommended applicants to medical school. Following the 1966 annual convention, this committee chairman directed a letter to the medical school dean, stating that while not all elements of the program could be satisfactory to every group concerned, it does provide the one specific program that can be counted upon to

provide family physicians to a rural population. Until adequate replacement of its functions is developed, it should not be eliminated in order to obtain additional school places that will be filled by prospects more likely to enter a specialty or non-practice research.

Interview Meeting in Bloomington:

On Dec. 27 and 28, 1966, the Joint ISMS/IAA Committee met in Bloomington at the IAA offices for a business and interview meeting. Twenty-six applicants to medical school in September, 1967 were personally interviewed, and 10 recommendations with two additional alternates sent to the admissions office of the University of Illinois. Unfortunately, the school committee on admissions elected to accept only six of these qualified applicants, and thus the potential of four additional family physicians in rural areas has been lost. Here again is pointed up the failure of our medical schools, both public and private, to consider the public's needs rather than just intellectual attainment—attainment that too often goes undisseminated to the areas of individual human need.

Annual Students' Dinner:

On Nov. 4, 1966, the Medical Student Loan Fund Board was host to the present medical school students participating under our program. A fine dinner was served at the Chicago campus student union building, with students and their wives expressing approval of the entire program. Bond L. Bible, Ph.D., secretary to the AMA's Council on Rural Health, was our after-dinner speaker; "Modernization of General Practice Training and Practice Throughout the Country" was the topic. Open discussion regarding the need for and available types of general practice residencies brought forth many candid and useful observations from physicians, IAA Board members and students.

Loan Fund Financial Status:

The total value of the Student Loan Fund at Dec. 7, 1966, was \$218,255. The assets of the fund at that date were:

\$82,000 U.S. Treasury bills
\$131,780 2% Student promissory notes
\$4,475 Cash

The fund received 2 percent interest income in 1966 amounting to \$3,057 including penalties of additional interest upon default of the contract terms; \$1,893 was received from investment in U.S. Treasury bills. The only expense of the fund in 1966 was \$1,320 for bank trust department administration fees. A trust fund surplus of \$3,630 resulted for the year.

Jack L. Gibbs, *Chairman*
Thomas C. Bunting Jacob E. Reisch
Charles N. Salesman

EDUCATIONAL & SCIENTIFIC FOUNDATION FB-4

The anticipated project from the Water Conditioning Research Council was not undertaken because of the loss of the coordinator and the inability to obtain a suitable replacement. It is hoped that this may still materialize during the current year.

The Board of Directors is pleased to announce the addition of the following Fellows during 1966:

J. Ernest Breed, M.D.
William M. Lees, M.D.
H. Kenneth Scatliff, M.D.
Noel G. Shaw, M.D.
Paul W. Sunderland, M.D.
Philip Thomsen, M.D.

The Directors also gratefully acknowledge a contribution of \$200 from Michael Saxon, M.D.

Merck Sharp and Dohme continued its support of the Scientific Speakers Bureau with a grant of \$5,000 which was presented at the meet-

ing of the Board of Trustees on Jan. 15.

As a means of raising funds, a project was established whereby contributors would receive a beautifully illuminated, mounted copy of either the Hippocratic Oath or the AMA Principles of Medical Ethics. It was modestly successful.

There were 18 requests for the film, "Modern Management of Multiple Births" from within the state. Reports from Lederle Laboratories, whose grant made the film possible, indicate the continuing interest from all over the country, with 402 showings in 1966.

At the 1966 Annual Meeting, Dr. and Mrs. Edward A. Piszczek and their four daughters presented to the foundation a solid gold medallion for use by the ISMS President. The medallion was hand crafted of three colors of gold and was gratefully accepted by President Burtis E. Montgomery.

Burtis E. Montgomery, *Chairman*

Arthur F. Goodyear

Caesar Portes

Jacob E. Reisch



Constitution & Bylaws

COMMITTEE ON CONSTITUTION & BYLAWS CB-1

The committee received suggestions for changes in the Bylaws from the House of Delegates, the Board of Trustees, a member of the board, the chairman of the Ethical Relations Committee, the Speaker of the House of Delegates, and from individual members of the society.

- A. The principle matter before the committee referred by the House of Delegates—the directive that the method of establishing committee structure be changed—will be the subject of a supplementary report to the House prior to the May 1967 meeting. This committee has received its first invitation to sit with the Committee on Committees at the time of the March meeting of the Board of Trustees, to consider their suggestions.

- B. Referred also by the House of Delegates were Resolutions 66M-1 and 66M-49.

Resolution 66M-1 (Jackson County) moved that the "bylaws (be amended to provide that) there will be no increase in dues . . . except this increase be voted on . . . in the regular annual meeting."

Resolution 66M-49 (Peoria) moved that "budgetary changes necessitating an increase in dues be presented to the component medical societies . . . at least 90 days" before they are considered by the House of Delegates.

This committee recommends that both resolution 66M-1 and 66M-49 NOT pass because they are too restrictive, because situations can and have arisen where actions must be taken without the delay that would be imposed, and because firm establishment of budgets 90 days prior to meetings and more than 10 months prior to effective date, is not realistic.

The committee is aware that the board is implementing a new policy of sending to each delegate, approximately 45 days prior to the annual meeting, a detailed projected budget for the ensuing fiscal year, and a notice of the recommended dues structure. We believe that such policy will serve the intent of the resolutions.

- C. Recommendation was received from a trustee of the society that this committee consider changes in the Bylaws to make eligible for membership in the society physicians who do not hold the degree of Doctor of Medicine but who are licensed to practice medicine in all its branches.

This proposal provoked much discussion. The final consensus was that this committee make no recommendations on this proposal at this time, but that we suggest to the society that the time may not be far distant when it may be desirable, advisable and equitable to make membership available to some of these paramedical groups.

- D. The committee reviewed a proposal that payment of dues by installments be authorized. We believe that this proposal should not be approved because the bookkeeping involved in crediting and accounting for partial payment of dues, as well as in allocating portions of the installment to the various components of the dues, (AMA, AMA-ERF, Benevolence, operating fund, etc.,) would make this almost impossible to administer. We are also aware that mechanisms exist for partial or complete remission of dues for cause. Therefore, the committee recommends that this proposal be rejected.

- E. The attention of the committee was directed to the fact that in some instances review committees of the Illinois State Medical Society (for example, the Ethical Relations Committee, or the Prepayment Plans and Organizations Committee) have the same membership as the constituent society committee whose decisions they are reviewing.

To correct this situation we propose that Chapter IX of the Bylaws, "COMMITTEES" be amended. (See appendix — Amendment to CHAPTER IX, Section 5B).

- F. The Speaker of the House, noting that when the election of officers is the first order of business at the final session of the House of Delegates, many delegates leave the assembly, thus making less representative the consideration of the remaining reference committee reports.

This committee agrees that consideration of current business—actually the reason for the assembly—should be the first task of the assembly, and we will propose amendments accordingly. (Appendix: Amendment to "ORDER OF BUSINESS").

In considering this amendment, your attention is directed to the deletion of Item 8, for reasons that will be evident in the supplementary report.

- G. Proposals were received from several sources—the Board of Trustees, the chairman of the Ethical Relations Committee of the Illinois State Medical Society, legal counsel for the Society—for changes in the procedures of the Ethical Relations Committee.

The Board of Trustees, at its meeting of July 23, 1966, directed that:

- G-1. The Ethical Relations Committee of the ISMS give 30 days (instead of ten days) notice of meeting to hear appeals from County Ethical Relations Committee verdicts, and

(See Appendix: Amendment to CHAPTER XII, Section 8 third sentence).

- G-2. All pertinent data to be furnished the committee by both plaintiff and defendant must be forwarded to the committee 10 days prior to the hearing, and

(See Appendix: Amendment to CHAPTER XII, Section 5 Paragraph 2, first sentence)

- G-3. That where either of the above requirements are not complied with, failure shall be grounds for a verdict of default against the negligent party.

(See Appendix: Amendment to CHAPTER XII, Section 5, and Section 8, last sentence in each)

The committee agrees that these measures act to enhance the deliberations of the committee, and we will propose amendments to the Bylaws to incorporate all three in the Appendix—CHAPTER XII, Sections 5 and 8.

The Chairman of the Ethical Relations Committee and the legal counsel for the ISMS both agree that the following three recommendations would protect both the individual member of the ISMS, and the members of the Ethical Relations Committee, as well as the society.

- G-4. That both parties, the ISMS Ethical Relations Committee and the defendant ISMS member, be allowed to have legal counsel present and participating in the procedures of the Ethical Relations Committee at county (or district) and state society hearings.

(See appendix: Amendment to CHAPTER XII, Section 1 and Section 4H (old G)).

- G-5. That once a complaint investigated by a Grievance Committee and considered by that committee to be worthy of review by an Ethical Relations Committee, the complaint must be presented formally in a

sworn statement signed by the complainant, and

(See Appendix: Amendment to CHAPTER XII, Section 4, new B).

G-6. That component society (or district) Ethical Relations Committees must conform as a minimum in their procedures, with the specific requirements of the ISMS Ethical Relations Committee.

(See Appendix: Amendment to CHAPTER VII, new second paragraph)

The attention of the committee was directed to the fact that although the Bylaws provide for District Ethical Relations Committees (and District Grievance Committees), the organization of these committees is not fully developed. We will attempt to make the Bylaws more specific in both instances.

(See Appendix: Amendment to CHAPTER VII and CHAPTER IX, Section 11)

This material will constitute the committee's written report for publication in the IMJ. However, supplementary reports will be developed and submitted at the time the House meets.

Andrew J. Brislen, *Chairman*

David S. Fox Wayne N. Leimbach

Nathaniel J. Kupferberg Donald G. Rumer

Consultant: E. W. Cannady, Speaker of the House of Delegates

APPENDIX TO ANNUAL REPORT OF CONSTITUTION AND BYLAWS, 1967 HOUSE OF DELEGATES AMENDMENTS TO THE BYLAWS

CHAPTER IV. ELECTION OF OFFICERS

AMEND Section 2—Paragraph 4

DELETE the first sentence and

SUBSTITUTE therefor:

"The election of officers and delegates and alternate delegates to the American Medical Association shall follow the completion of action on current and old business at the final session of the House of Delegates"

CHAPTER VII. DISTRICT COMMITTEES

AMEND

ADD at the end of the first paragraph:

"Complaints initially received by district committees shall be referred immediately to the component society for action."

ADD A new paragraph two:

"District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws."

CHAPTER IX. COMMITTEES

AMEND

DELETE: Section 5-B

SUBSTITUTE a new Section 5-B to read:

B. "No member of a county or district com-

mittee whose actions at the county level are subject to review by a state committee, may be a member of the state review committee, and"

DELETE old paragraph C and

RELETTER: Paragraph D to paragraph C.

DELETE from old paragraph D (new paragraph C) the words:

"for more than three consecutive terms or" and the paragraph will read:

C. "No member may serve on any committee for more than nine consecutive years".

AMEND Section 11. *Grievance Committees*

DELETE Paragraphs 1, 2 and 3 and by

DELETING Paragraphs A and B from paragraph 4 to make a single sentence:

"It shall be the function of the State Society Grievance Committee to conduct a continuing study of the complaints against the medical profession of the State of Illinois and to make recommendations to improve the quality of medical care."

The rest of the section remains the same.

CHAPTER XII. DISCIPLINE

AMEND Section 1. *Local Ethical Relations Committee.*

ADD a new paragraph 2 to read:

"The component society (or district) Ethical Relations Committee may employ legal counsel."

AMEND Section 4. *Principles of Justice.*

ADD a new paragraph B to read:

"B. Informal charges of unethical conduct reviewed by a component society and considered grounds for formal charges before the Ethical Relations Committee of the component society or district Ethical Relations Committee, must be presented under oath by the complaining party.

RENUMBER:

Old paragraph B— is paragraph C.

C— is D

D— is E

E— is F.

F—is G.

G—is H.

AMEND new paragraph C (old paragraph B) by INSERTING after the first word—the word "formal" so that the paragraph reads:

"C. After *formal* charges have been preferred there shall be no evasion of the fact that . . . etc."

AMEND new paragraph H (old paragraph G)

ADD at the end of item (1) "and/or by legal counsel" so that the paragraph reads:

"H. The respondent shall be advised of his rights by the trial body, namely:

(1) that he may be represented by any member of the society as counsel, and/or by legal counsel . . . etc."

AMEND Section 5. *Records*

ADD a new paragraph 2 as follows:

"In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record shall be forwarded by certified mail to the Board of Trustees of the ISMS ten days prior to the date the appeal is to be heard. Failure to provide such records shall be grounds for a verdict of default against the component society."

AMEND Section 8. *Appeals from Component Society Verdicts.*

ADD after the first sentence, a new sentence as follows:

"Appeal must be accompanied by pertinent data and transcripts indicating the basis for the appeal. Failure to provide such data shall be ground for a verdict of default against the plaintiff."

AMEND the next sentence by

DELETING the word "ten" and

SUBSTITUTING therefor the word "thirty" to read:

"The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal."

So that Section 8 will now read:

"Section 8. *Appeals from Component Society.* Appeals received by the ISMS Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. Appeals must be accompanied by pertinent data and transcripts indicating the basis for

the appeal. Failure to provide such data shall be grounds for a verdict of default against the plaintiff. The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees."

**ORDER OF BUSINESS OF THE
HOUSE OF DELEGATES
Last Session**

Old #	New #
1.	1. Call to order
2.	2. Report of Committee on Credentials
3.	3. Roll Call
11.	4. Reports of Reference Committees
9.	5. Fixing of per capita tax for ensuing year
10.	6. Selection of meeting place for next annual meeting. (Subject to the investigations of the Board.)
12.	7. Unfinished business
	8. Election of
4.	a. officers
5.	b. trustees
6.	c. delegates to the AMA
7.	d. alternate delegates to the AMA
13.	9. Induction of President Elect into the office of President
14.	10. New business
15.	11. Adjournment. (sine die)



Opinion Research Survey

TASK FORCE TO STUDY THE OPINION RESEARCH SURVEY OR-1

Considerable time was spent in conferences with the chairman of the board and other trustees, the president and other officers, the executive administrator and his staff, and various interested individuals to select the membership of the Task Force to Study the Opinion Research Survey.

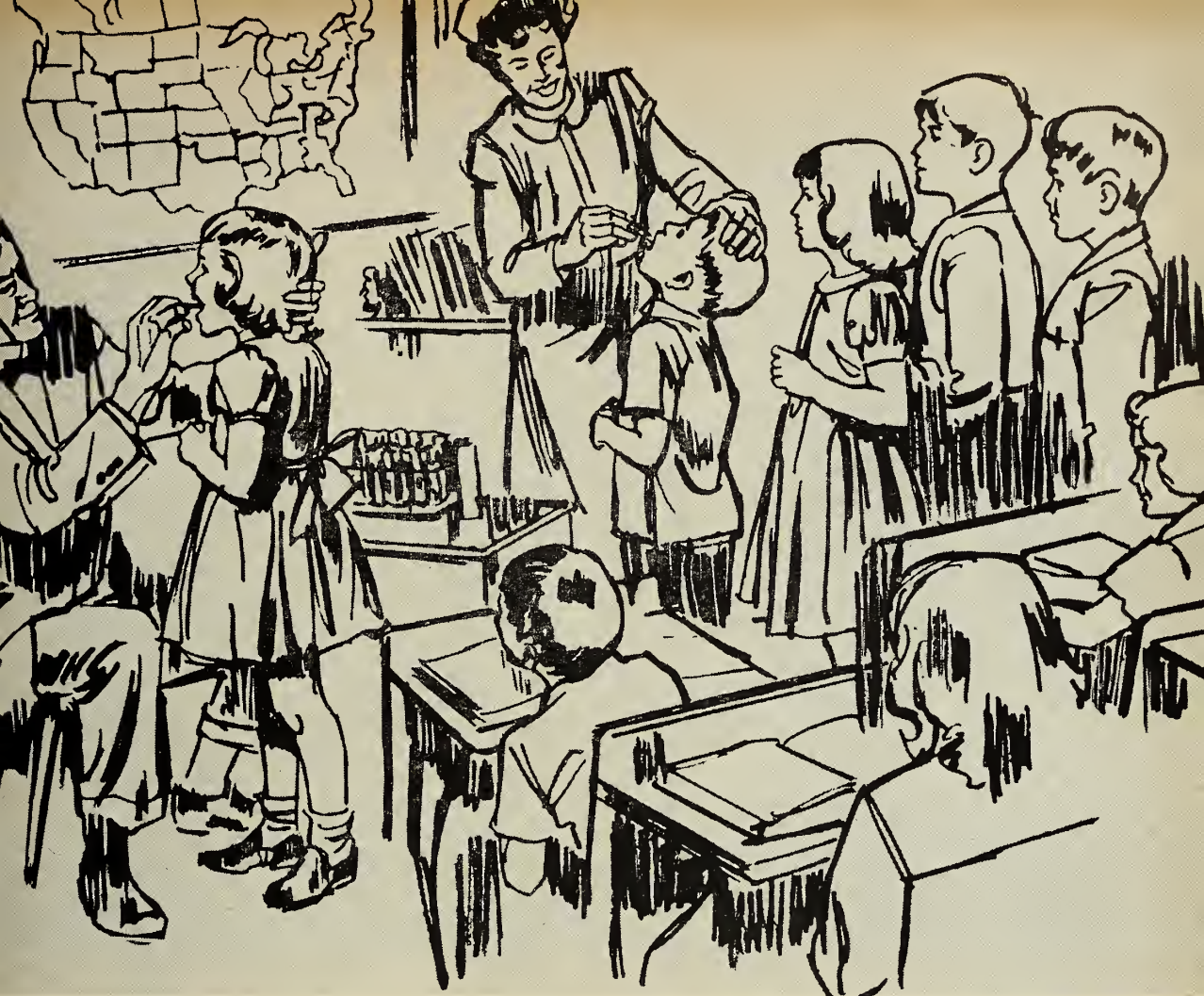
The task assigned is a prodigious one, for while the diagnosis is obvious, the treatment is obscure. It is hoped that a positive action program will evolve to treat the malignant apathy that assails far too many members of the Illinois State Medical Society.

At the time this report is submitted, two more meetings are planned before the House of Delegates convenes. Of the recommendations to be suggested, surely the most important one will be to urge a continuing study.

Newton DuPuy, Chairman

William E. Adams, Vice Chairman

Allison L. Burdick, Jr.	Maurice Murfin
Edward W. Cannady	Raymond W. Nemecek
Raymond H. Conley	Edward A. Piszczek
Keith H. Frankhauser	Norman Powers
Jack Gibbs	Edward A. Razim
John J. Holland	Jacob E. Reisch
Mack Hollowell	Charles N. Salesman
Jerry Ingalls	H. Kenneth Scatliff
Gerald S. Laros	V. P. Siegel
William M. Lees	Burton Soboroff
George F. Lull	Paul W. Sunderland
John D. McCarthy	Leo P. A. Sweeney
Coye C. Mason	Paul Van Pernis
Kenneth Morris	Francis W. Young



Publications & Scientific Services

COMMITTEE ON ALCOHOLISM PS-1

The newly-established committee held two formal meetings and the chairman met with Mr. Boeck on three other occasions to set up the plan for meeting the objectives assigned to the committee.

Preparatory to establishing projects for the committee, every state medical society, state agency dealing with alcoholism, and several other organizations were asked to submit information concerning their programs. Replies were received from 46 state medical societies and 35 state agencies.

After perusing the returns, the chairman then drafted an evaluation form on which to record the salient information about each program. The committee reviewed the form, modified it to suit their needs, and each member was given copies along with a share of the material submitted from across the nation.

At this point, each member is studying the various state programs and recording on the forms the information needed to guide the committee in formulating a plan for its future activities.

The ultimate goal is to formulate a program which will enable the physician to diagnose, treat and prevent alcoholism, and to educate the public along similar lines by coordinating medical society efforts with other community groups also involved with the broad problem of alcoholism.

Abraham Gelperin, Chairman

Charles L. Anderson
Gerald H. Becker
Richard S. Cook
Richard Eisenstein
Dale M. Learned

Robert A. Moore
Jackson A. Smith
J. C. Troxel
Frank J. Walsh
William H. Wehrmacher

COMMITTEE ON CANCER PS-2

Following action by the ISMS Board of Trustees, favoring the performing of Pap smears as routine procedure on admission to all hospitals in Illinois, the chairman notified the Illinois Division, American Cancer Society, of desire to work jointly on obtaining implementation of such a policy by the hospitals.

A meeting was held on Aug. 11, 1966, to discuss

the matter. It was decided that, prior to approaching the hospitals with a request concerning routine Pap smears, it would be wise to muster as much support from as many medical organizations as possible.

To this end, a letter was sent out under the signature of Walter L. Palmer, M.D., President, American Cancer Society, Illinois Division, and Caesar Portes, M.D., President, Illinois State Medical Society. The letter solicited support of the plan. It went to:

Illinois Department of Public Health
Illinois Society of Pathologists
Chicago Gynecological Society
Institute of Medicine of Chicago
Chicago Surgical Society
Illinois Society of Internal Medicine
Chicago Society of Cytology
Illinois Section, American College of
Obstetricians and Gynecologists
Illinois Surgical Society
Illinois Academy of General Practice
Chicago Pathological Society

At the time this report was prepared, replies were still coming in, but the response was entirely in favor of the recommendation. Upon receipt of answers from the group, a further meeting will be held to plan how to proceed. It is expected that the program will win acceptance by the hospitals and will be supplemented by an educational campaign to explain to the physicians and the patients the wisdom of such a policy.

Andrew J. Toman, *Chairman*

Michael H. Boley	R. A. Kowal
Warren H. Cole	Rudolph G. Mrazek
Angelo P. Creticos	Wilson R. Scott
Robert E. Field	T. Sellett
Russell M. Jensen	R. F. Sondag
Caesar Sweitzer	

CONSULTANTS:

J. Ernest Breed	Caesar Portes
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AUXILIARY REPRESENTATION:

Mrs. Richard E. Icenogle

COMMITTEE ON CARDIOVASCULAR DISEASE PS-3

No report submitted.

Oglesby Paul, *Chairman*

Wright Adams	Charles A. Gianasi
Kurt Biss	Arnold S. Moe
E. L. Borkon	Roy G. Nagle
Hugh S. Espey	A. Paul Naney
Eugene J. Scherba	

COMMITTEE ON CHILD HEALTH PS-4

The committee dealt with a rather large number

of items during the year and submitted the following to the trustees for approval:

1. Establishment of a sub-committee to study the problem of financially catastrophic diseases and the best method of providing medical care for patients with hemophilia, asthma, chronic nephritis, and others. The sub-committee will study the prevalence of these diseases and existing state and federal programs which are available to provide care for indigents.

2. Amendment of the school code to require compulsory immunization before a child is admitted to school. Furthermore, it is the recommendation of the committee that all immunization procedures accepted as essential and recommended by the American Academy of Pediatrics to be initiated in early infancy be re-emphasized by continuing professional and lay education through mass media, sponsored by ISMS. The committee further recommends that such examinations and immunizations be carried out in the offices of private physicians wherever practical or feasible; and that the State Department of Public Health seek the cooperation and assistance of the county and state medical societies in carrying out these procedures.

3. Approval of a plan of the State Department of Public Health to establish training programs for audiometric technicians.

4. Disapproval of the use of amniocentesis solely for the purpose of determining the sex of an unborn child.

5. In the area of school athletics:

A. Recommend that a physician be in attendance at all high school football games and readily available to all other body contact sports.

B. Recommend that in the case of BK amputee, the determination concerning participation in inter-scholastic sports be left to the medical team, the coaches, and the student's parents.

C. Recommend that pre-season physical examinations for athletes include testing of muscles for strength, flexibility, and range of movement.

D. Recommend revising the physical examination standards required of girls participating in interscholastic sports.

6. In view of the current regulations concerning physical examination for school teachers, it was recommended that teachers be required to have periodic physicals. Recommended standards for these examinations are being developed now and after approval will be forwarded to the proper state authorities.

7. Recommend to the Department of Public Instruction that all high schools include courses in health education in family living.

8. Recommend that the Illinois Division of Services for Crippled Children in cooperation with the

State Department of Public Health, make available special centers wherein there would be developed special interest in the diagnostic and medical care problems of infants with phenylketonuria.

9. Recommend that the ISMS Eye Health Committee develop standards of eye health for use by the Department of Public Instruction and that all medical information disseminated by DPI be approved by a medical authority.

10. Support the statement of the USPHS and BCG, opposing the use of BCG in mass immunization programs.

11. Seek adoption by all schools in Illinois of one of the three school health forms devised by the committee and approved by the ISMS trustees.

All of the above were approved by the Board of Trustees during the year.

Ralph H. Kunstadter, *Chairman*

Irving Abrams	Edward F. Lis
William J. Ball	Fred Long
Oliver W. Crawford	J. Keller Mack
Eugene F. Diamond	Franklin A. Munsey
Richard E. Dukes	Kenneth S. Nolan
W. W. Fullerton	T. A. Palus
Robert C. Hamilton	Leo G. Perucca
Edmond R. Hess	Walter G. Steiner
Howard R. Hone	Norman T. Welford
Eduard Jung	W. M. Whitaker

COMMITTEE ON CONTINUING EDUCATION PS-5

The major activity of the committee continued to be the Scientific Speakers Bureau, which is at about the same level as in previous years.

A total of 79 physicians participated during 1966, appearing in 17 counties. Those counties utilizing the services of the bureau were Bureau, Carroll, Coles-Cumberland, DeKalb, Green, Jo-Davies-Carroll, Kane, Knox, LaSalle, Livingston, Cook, Montgomery, Rock Island, Stephenson, Vermilion and Whiteside. The heaviest users were Livingstons (10 speakers), Kane (9), LaSalle (9), Coles-Cumberland (8), DeKalb (8), Bureau (6) and Knox (5).

Almost 4000 (3935) post card notices were mailed to 32 counties in connection with these meetings.

One postgraduate program was produced, in cooperation with the Tazewell County Medical Society in April. Five speakers participated and more than 500 programs were mailed in eight counties in the Peoria area.

The reports on the speakers were more complimentary than in the past and the speakers seemed to feel that the service was greatly appreciated.

Merck Sharp & Dohme graciously continued its support of the bureau and Mr. J. F. Head, attended the meeting of the Board of Trustees in January to present a check for \$5,000 for 1967. Although the trustees expressed their appreciation for this grant,

it is recommended that the House of Delegates also extend similar appreciation.

The committee met in September, with Dr. Robert Drye of the Illinois State Mental Health Department to discuss an educational program for the partially licensed physicians in the department.

As a means of preparing these physicians for the examination, the department proposed a 16-week course of instruction, consisting of two one-half days each week, with emphasis on those subjects with a high failure rate. The aid of ISMS in obtaining the cooperation of medical schools in providing faculty was requested and the following recommendations were approved at the October meeting of the Board of Trustees:

1. Resolved, that ISMS acknowledge its responsibility to a program that recognizes the legitimate needs of those physicians in the Department of Mental Health who need educational instruction to elevate their standards in order to obtain full licensure from the State of Illinois.
2. Resolved, that ISMS pledge its support, cooperation and assistance in obtaining a proper faculty as recommended by the Department of Mental Health.
3. Resolved, that ISMS enlist the cooperation of the medical schools to obtain faculty members as needed according to the recommendations of the Department of Mental Health.

These resolutions were presented at a meeting of the deans of the medical schools and the ISMS Executive Committee, and Dr. Drye reported at the January Board Meeting that the response from the medical schools had been very satisfactory.

Robert J. Freeark, *Chairman*

W. E. Adams	John L. Keeley
Hubert L. Allen	Louis R. Limarzi
George Block	Edward S. Petersen
T. Howard Clarke	Paul S. Reeder
Leonard D. Grayson	Gordon H. Sprague
Edwin N. Irons	William R. Thompson
Louis N. Katz	Leo M. Zimmerman

ENVIRONMENTAL HEALTH PS-6

Proposed Future Activities

In addition to continuing our regular activities in the field of water pollution, air pollution, spread of food poisoning and food infections through environmental hazards or contamination, etc., a special effort in the area of the pollution of underground water tables is anticipated.

Correspondence has been held with Mr. Neilson Rudd, President of the Illinois Section of the American Institute of Professional Geologists. A three-way effort is planned between our committee, the State Sanitary Water Board and the Geological As-

sociation concerning the geologic implications of underground waste disposal projects and their possibilities for wide-spread water pollution.

Activity During Past Year

Prevention of disability and death from the environmental hazard posed by the rapidly increasing use of laser systems

As a result of a new potential hazard in the environment, posed by the rays of electro-magnetic energy in both the visible light spectrum and the invisible rays emanating from laser systems, special efforts of the committee during the past year have been directed toward developing safety guides and legislation to help reduce these hazards. The chairman of the committee by a combination of literature review plus correspondence and telephone calls with medical and physical scientists active in the field on a national level drafted a statement of "Recommended Safety Precautions for the Use of Laser Systems". The revised draft of this statement was circulated to members of the committee and a letter ballot was taken regarding its adoption. It passed without a dissenting vote. This statement will be copyrighted by the Illinois State Medical Society and given wide distribution in this state and other states.

In addition, a bill was drawn up with consultation from the legal staff of the Illinois State Department of Public Health that would require registering laser systems and reporting accidents causing injuries, blindness, or death. This bill has been approved in principle by the Legislative Committee of ISMS and when final approval has been obtained, the society will seek a sponsor to introduce it into the 75th General Session of the State Legislature in Springfield.

Restaurant Licensing Bill

A bill requiring inspection and licensing of all restaurants and related food service establishments in the state not already covered by adequate inspection and licensing laws of municipalities or counties has been prepared under the aegis of the committee. Approval by the Legislative Committee of ISMS and sponsorship and introduction into the State Legislature is being sought. At the present time many restaurants in cities and counties without local ordinances or health departments have restaurants in which no prior inspection or licensing is required. In a significant percentage of these instances, new restaurants may open with substandard equipment, inadequate refrigeration and storage facilities and poor sanitary procedures and may be in operation for a period of weeks or months before coming to the attention of the State Department of Public Health for inspections. In some of these instances the requirements for correcting various violations and providing the necessary dishwashing, refrigeration, heating, etc. is so difficult and costly that bankruptcy proceedings may be required.

Prevention of Disability and Death from Burns as a Result of Flammable Fabrics

During the past two or three years the committee has worked on this problem in conjunction with the Public Safety Committee of the Society. A bill was passed in the 74th General Assembly but was vetoed by the governor on constitutional grounds because of certain technicalities. This bill has been redrafted to overcome the major technical difficulties and has had blankets and bedding in hospitals, nursing homes and hotels included in its provisions. The bill is currently being sponsored by the Society and efforts to obtain its passage and enactment into law are under way.

Summary

The committee has been particularly active during the past year in developing a statement of "Recommended Safety Precautions for the Use of Laser Systems" and introducing a bill requiring registration of laser systems and reporting of injuries, blindness, or death caused by such laser systems.

In addition two bills are being introduced into the 75th General Assembly under committee aegis. One would require restaurants in areas previously exempt from state and local licensure to be inspected and licensed. The other would prohibit dangerously flammable fabrics to be used for clothing or for bedding in hospitals, nursing homes, hotels and motels.

Edward Press, *Chairman*

H. Burkhead

James B. Hartney

E. C. Holmblad

Ralph Kunststadter

R. J. Maganini

Clarke W. Mangun, Jr.

Joseph H. Skom

Franklin D. Yoder

COMMITTEE ON EYE HEALTH PS-7

In accordance with its responsibilities and purposes, the committee has been on the alert for misleading and fallacious programs and information which need correction for the protection of the public.

So far only one such situation has arisen in 1966-67. The Chairman of the Child Health Committee of the ISMS asked this committee's opinion regarding a news letter distributed by the Office of Public Instruction in which the American Optometric Association attempted to give the school teachers guidelines regarding the recognition, by the school teachers, of eye symptoms that should serve as a basis for referral of the child to eye specialists. The opinions of the members of the committee were polled by telephone and letter. The reply to the Child Health Committee was to the effect that the Eye Health Committee considers the distribution by school authorities of a pamphlet referring to strictly

medical matters issued by the optometric profession as unwise and improper.

The Eye Health Committee has been apprised of the impending formation of an Illinois State Joint Council of Ophthalmology which will function as an arm of both the Chicago Ophthalmological Society and the Illinois Society of Ophthalmology and Otolaryngology. It will provide a forum to discuss ophthalmological problems in the area of public affairs and legislation and to seek a unified posture of all Illinois ophthalmologists in these important matters. The establishment of this council may be expected to broaden the scope of activity of the Eye Health Committee.

During the remainder of the year the Committee on Eye Health will continue to function as an advisory group to provide information in its area of competence when the need arises. No new activities are planned.

Peter C. Kronfeld, *Chairman*

Chester J. Black

Daniel Snyder

T. William Cook

Walter Stevenson, Jr.

Burton M. Krimmer

Manuel L. Stillerman

M. Byron Weisbaum

MATERNAL WELFARE COMMITTEE PS-8

Your Maternal Welfare Committee has conducted three meetings since last reporting to you. The review of 67 cases in which there was a possibility of maternal mortality was completed. It is interesting to note that in 30 instances death was thought to be due directly to some complication of the pregnancy. In 18 instances it was thought that pregnancy, by its aggravation of a pre-existing condition, brought about the patient's demise; and in 19 instances, the situation was such that there was no implication that the pregnancy contributed in any way to the patient's death.

Hemorrhage continues to be the leading cause of death throughout the state followed by infection and then vascular accidents. Toxemia seems to be playing a declining role.

Physician interest in the affairs of the committee continues to be high. It is impossible to give you the figures for the number of inquiries which will result from the last meeting of the committee, held on Feb. 12; but for the previous two meetings, at which time 41 cases were coded, 12 letters of inquiry requesting the committee's opinion were received and in seven instances, the physician or physicians responsible for management of the situation were present to join in our deliberations.

We continue to be grateful for the presence of Dr. Szanto at our meetings whenever it is possible for him to attend. The clarity of his explanations of pathological features of maternal situations continues to add to the store of knowledge of each member of the committee. We also feel privileged to have

at our meetings, Dr. Webster and the house officers on the obstetrical staff of Cook County Hospital. Their knowledge of current obstetrical advances is of help to your committee and a credit to their preceptors. In addition, your committee hopes that in some small degree at least, their presence at our deliberations adds to their fund of knowledge, which will soon be made available to the mothers of Illinois.

Your committee continues to be honored by requests for its opinion on matters concerning obstetrical care throughout the state. We feel a sense of chagrin with overtones of frustrating disappointments at our inability to carry out the direction of the reference committee of the House of Delegates relative to documenting the necessity for modernizing the state abortion laws by "statistical study and precise delineation". There seem to be many reasons for this. The most cogent, however, seem to be that those physicians who do not believe in performing abortions for any reason will certainly not report any cases in which the need for abortions existed. It is felt that physicians who are practicing in areas where a liberal interpretation of the law is allowed will not report cases lest subsequent investigation in activities in their areas dry up the opportunity for securing these abortions. This, of course, leaves only a frustrated minority who may feel the need for abortions in some of their patients, but be averse to participating in what constitutes illegal activity. Disappointing as have been our attempts to gain information in this way, your chairman has been active in exploring the need for modernization of the law. We were most pleased to be able to participate in a dialogue with Dr. Eugene Diamond which was aired for one hour over a Chicago radio station and which proved to be of sufficient interest to justify another hour program at which time questions from the general public were answered by the two participants.

In addition to that, your chairman with the professional help of an ad hoc committee consisting of Drs. Louis Boshes, Arthur Fleming, H. Close Hesselstine, William Hill, Robert Mendelsohn, and Newton DuPuy aided by the very competent lay help of Mr. Al Boeck and Mr. Paul Swarts has set up a day long meeting at which the medical implications of the current abortion law in Illinois were discussed by representatives of the specialties of obstetrics, pediatrics, psychiatry, and public health. Proponents and opponents for change of the laws were called upon to present their views, and during the afternoon questions from the audience were referred to the panel participants for answers. The program was televised, and your committee feels it was a great aid in the determination of the attitude which medicine should take with relation to this vital, yet controversial subject.

Other areas in which the cooperation or opinion of the committee was requested consisted of the

need for an improvement in prenatal care currently available to indigent patients; preliminary discussion relative to modification of the forms for recording the details for prenatal and obstetrical care; the mixing of clean gynecological with obstetrical cases; the participation of the physicians of Illinois in a pilot study relative to physical and personnel facilities available for maternal care throughout the state as well as other items having specific implications to maternal well being.

In closing, the chairman of your committee wishes to express his appreciation to the delegate members of the committee without whose advice and counsel nothing could have been accomplished. It is our feeling that recognition of a deep debt of gratitude should also be made regarding the services to your committee of its consultants, Dr. John Louis of the hematology section of the Department of Medicine of the Stritch School of Medicine; Dr. John Rendok, Consultant in Maternal Welfare; and Dr. Augusta Webster, Chief of Obstetrics, Cook County Hospital. It is your committee's constant object to protect parturients throughout the state by an improvement in maternal care.

Robert R. Hartman, *Chairman*

V. B. Adams	George E. Griffin
Hubert L. Allen	Charles D. Krause
Donald M. Barringer	William R. Larsen
Jack D. Brodsky	Harry L. Lewis
William W. Curtis	Philip C. Lynch
George E. Fagan	John J. McLaughlin
Frederick H. Falls	Paul A. Raber
Hugh C. Falls	Berry V. Rife
William J. Farley	Donald R. Risley
Ralph L. Gibson	James B. Stotlar
Melvin Goodman	Charles H. P. Westfall

CONSULTANTS:

Donaldson F. Rawlings	W. C. Scrivner
John H. Rendok	Augusta Webster
John Louis	Franklin D. Yoder

COMMITTEE ON MEDICAL EDUCATION PS-9

With all the members of the committee holding appointments on the Ad Hoc Committee on Special Problems of Medical Education, most of the functions of the committee were performed with the ad hoc committee and will be reported in the annual report of that group.

The committee did, however, function independently on one occasion to select a nominee for the Hamilton Teaching Award, sponsored by the Interstate Postgraduate Medical Association of North America. In a telephone conference call, the committee nominated Dr. Charles B. Huggins, Professor of Surgery at the University of Chicago, and recent Nobel Prize winner. The nomination was subsequently approved by the Board of Trustees.

A meeting was called to discuss ISMS opposition to HB 25 which seeks to permit the charging of fees for physician services rendered at the University of Illinois R & E Hospital. It was explained that when the Hospital was established in 1931, it was specifically prohibited from collecting such fees for professional services.

Dean Bennett reviewed the operation of the College of Medicine, and indicated that this prohibition of fees is no longer proper or desirable. HB 25, although good in its intention, is not acceptable by ISMS because it conflicts with the AMA Principles of Ethics.

To overcome this objection, Dr. Caseley has prepared a plan which should be acceptable to the University authorities, the practicing physicians and the Legislature. It is hoped that HB 25 can be amended, or rewritten, on the basis of the plan.

After discussion of the various aspects of the plan, and the possible reaction by private physicians, and the insurance industry, the following motion was adopted and referred to the Legislative Committee:

The Committee on Medical Education approves in principle the Medical Service Plan for the University of Illinois College of Medicine, and the Research and Education Hospitals, subject to further exploration by the ISMS Legislative Committee, the insurance industry and Blue Shield, and a satisfactory mechanism being created to handle the funds involved.

Also, in reply to a request for an accounting of the 1966 AMA-ERF grants, the medical schools replied as follows:

Northwestern University

Please excuse the delay in answering your letter of February 9, 1967. Dean Young has been ill and I unfortunately put this item too far down in the stack.

At the outset let me say AMA-ERF funds have done us a very great service through the years. They have allowed us to establish a number of new positions which otherwise could not have come into being.

At earlier times it was our practice to use these funds as "seed money" for new positions. After a few years, in each case, it became possible to shift the source of salary for such positions onto other funds some of which have been Federal in nature.

However, in recent times it has become necessary to count on these funds for the perpetuation of much needed positions. Therefore, in addition to expressing our sincere thanks for past favors, we must earnestly hope that the AMA-ERF program can be perpetuated at its present level.

In response to the specific portion of your request I offer the following list of individuals and

the funds which they received from AMA-ERF during the past year.

Orr, Mary F.	\$7,500
Department of Anatomy	
Everingham, John	5,000.00
Department of Anatomy	
Eckenhoff, James	11,611.44
Department of Anesthesia	
Bluefarb, Samuel	7,500.00
Department of Dermatology	
Ekstedt, Richard	7,500.00
Department of Microbiology	
Total	<hr/> \$39,111.44

Sincerely,
J. A. Wells, Ph.D., M.D.
Associate Dean

Chicago Medical School

During the academic year of 1965-66, The Chicago Medical School was the recipient of \$27,919.94 received in May, 1966, from the AMA-ERF. This generous gift has been of great help to us in our educational and research program. In the past, it has gone into general funds and utilized in a manner that best supports the teaching program, and as such, is difficult to determine its exact disposition. It has been used to supplement the ever increasing salary scale of approximately six full-time teachers in the amount ranging from \$1,500 to \$2,000 and an equal number of research professionals involved with student research projects. In the future a detailed accounting of the exact amounts will be available.

There is very little doubt that this is of vital need in the maintenance of a high quality of educational activity, and we are most appreciative of your consistent generosity.

Sincerely,
LeRoy P. Levitt, M.D.
Dean

University of Chicago

Dr. Leon O. Jacobson has asked me to respond to your letter of February 9, 1967 concerning our use of the AMA-ERF funds. As he noted in his letter last year, these funds have been extremely useful to us. This year, as in the past, their presence has been most important as we plan the future of this medical school. I am sure you are aware that the unrestricted nature of these funds has made them among the most valuable we receive.

Specifically, this year we have turned our attention to two areas in the Medical School which had urgent needs. The first of these is cardiovascular surgery. Although we did have competence in this field in the past, we have felt that this department had to expand to meet the in-

creasing demands of our country for individuals well trained in cardiovascular surgery. Medical cardiology at this University has grown tremendously in the past few years, and in order to meet the needs of our physicians, it was decided to expand our cardiovascular-surgical unit. In order to do this, new members of the faculty had to be appointed. I am happy to report to you that as a result of the funds made available through the AMA-ERF, we were able to appoint Dr. C. Frederick Kittle as Professor of Surgery and head of the division of thoracic and cardiovascular surgery in the Department of Surgery. Dr. Kittle came to us from the University of Kansas School of Medicine where he had done important work in the field of cardiovascular surgery. In addition to his interests in this field, Dr. Kittle has a profound interest in the history of medicine, and while at Kansas he was a lecturer in the history of medicine as well as Associate Professor of Surgery. Had it not been for the contribution from the AMA-ERF funds to our medical school, we would have been unable to make this appointment since our budget had already been committed at the time of his appointment. I am happy to state that as a result of Dr. Kittle's appointment, the cardiovascular-surgical unit has become more active than it was in the past, a fact which is attested to by the increased census on that service in the hospital, and by the increased number of complex cardiovascular lesions which are being treated surgically. The success of this endeavor is apparent, not only to those of us who are here at the hospital, but also to the public, since some of these successes have been reported in the local press. I believe that we can look forward to an increasingly important role of this department in the well being of our community and in the production of scholarly individuals who will be leaders in this field and who will help to man the units in other parts of the country which will be established as a result of the regional health programs.

I would now like to turn my attention to another important appointment which is the result of the grant given to us from the AMA-ERF. This is the appointment of Professor George Eisenman to the Department of Physiology. Dr. Eisenman comes to us after a distinguished career at other universities. He is an expert in the field of transport of ions across membranes. I am sure you are aware of studies done in this field, but I cannot emphasize their importance enough in this letter. The whole field of ion transport is one which is undergoing intensive study at the present time. Although Dr. Eisenman's efforts are directed at studies done with models and with membranes which seem somewhat remote from application to human physiology, these basic researches will help us in future years in our un-

derstanding of the problems associated with disturbances in electrolyte balance in patients suffering from many diseases. Dr. Eisenman is a distinguished member of the small group of individuals responsible for most of the significant advances in this field. He is recognized both nationally and internationally as one of the outstanding scholars in this area, and we are proud to have him as a member of our faculty. It is through the donation from the AMA-ERF fund that we were able to make the appointment of Dr. Eisenman. He has been extremely productive since he has been here, and his productivity will continue in the future.

In closing, let me emphasize again the importance of these funds for our medical school. It is most urgent that we have this kind of "free" money so that we can make appointments at times when our budget is severely restricted. I hope that the fund will grow so that our ability to continue the improvement in our educational program will be enhanced in the future.

Should you need further details concerning this, please do not hesitate to write.

Sincerely yours,
Robert G. Page, M.D.
Associate Dean

University of Illinois

I am glad, in response to your letter dated February 9, 1967, to provide information on the manner in which AMA-ERF funds have served the interests of the University of Illinois College of Medicine during the year beginning July 1, 1965.

These funds are maintained by the University in a separate account and are used only for purposes which the faculty and administration of the College of Medicine consider important and appropriate.

In the period covered by this report, five departments of the College (Medicine, Microbiology, Pediatrics, Psychiatry and Surgery) received support for highly essential teaching and patient care activities which otherwise could not have been implemented for periods of one or two years at the earliest. Total or partial salaries were provided for the following kinds of staff personnel:

- 1) Instructor in Medicine
- 2) Instructor in Pediatrics
- 3) Instructor in Psychiatry (Child Psychiatry)
- 4) Visiting lecturers in Microbiology
- 5) Instructor in Surgery (Vascular Surgery Program)

A small amount of AMA-ERF funds were also used to enhance special programs in residency training in Medicine and Surgery. These funds have been and continue to be invaluable in that they enable the College to make necessary adjustments in acquiring and retaining staff and in financing

new or modified programs in interims between budget appropriations. We are tremendously appreciative of the help this resource has provided.

Sincerely yours,
Granville A. Bennett, M.D.
Dean

Loyola University

As Mr. Richards requested in his letter of February 9, the following is a breakdown of the allocation of the AMA-ERF funds which were received by this School. All of the funds were used to provide the salaries or part of the salaries of the following full-time basic science teachers:

Alexander H. Friedman, Ph.D.	\$15,000
Assistant Professor, Dept. of Pharmacology & Therapeutics	
Allen A. Rovick, Ph.D.	12,500
Associate Professor, Dept. of Physiology	
Joseph R. Davis, M.D.	4,671
Associate Professor, Dept. of Pharmacology & Therapeutics	

\$32,171

The above information was given to your secretary by telephone, today, March 15th.

Sincerely yours,
John F. Sheehan, M.D.
Vice President for the Medical Center & Dean, Loyola University Stritch School of Medicine

Daniel J. Ruge, *Chairman*

Herschel Browns	Wm. F. Hubble, Jr.
D. H. Dexter	Clifton Reeder
Leonard D. Grayson	James A. Weatherly

AD HOC COMMITTEE ON SPECIAL PROBLEMS OF MEDICAL EDUCATION PS-10

1. During the year, "The Graduate Education of Physicians" and "Meeting the Challenge of Family Practice", were issued by the AMA. Because of the potential effect of these reports on the future of medical education, copies of both were obtained and distributed to the committee.

In anticipation of the AMA action on the reports at the annual convention in June of 1967, the committee met to prepare recommendations for the guidance of the Illinois delegation. Because of the importance, complexity and number of recommendations, in the Millis Report in particular, it was deemed necessary to go over the report item by item at the subsequent meeting in April. It is planned to submit a supplementary report containing these recommendations.

2. At its February meeting, the committee dis-

cussed the merits of state subsidies for private medical schools and adopted the following resolution:

That the Illinois State Medical Society support in principle the concept of a state subsidy to the private medical schools in Illinois to enhance the progress of all medical education in the state, and that such a program not in any way impede or inhibit the funding for the University of Illinois College of Medicine or prevent consideration, or future establishment of a new medical school.

3. The 1966 resolutions favoring the establishment of preceptorship at the medical schools were presented to the deans at the meeting in October. As a result, the Chicago Medical School agreed to offer an elective preceptorship if ISMS would plan it. Dr. Norman Frank was appointed chairman of a committee to prepare a prospectus and arrange all the details. The program initially will be in Du Page County for a twelve-week period and will involve both large and small community hospitals as well as private physician's offices. At the time this report was written, the committee was submitting the program to Dean LeRoy Levitt for final approval. If adopted, the preceptorship program will be offered for the first time in June, 1967.

Daniel J. Ruge, *Chairman*

E. Chester Bone
Herschel Browns
Morton C. Creditor
D. H. Dexter
Jack Gibbs
J. M. Ingalls
C. J. Jannings
Kenneth F. Kessel
Boyd E. McCracken
Morgan M. Meyer
Robert G. Page

Edward S. Petersen
Clifton L. Reeder
William R. Rich
A. L. Robinson
S. L. Ruggero
Melvin Sabshin
Robert J. Schafer
Howard Schneider
S. E. Schubert
Carl J. Weissmann
Fred Z. White

CONSULTANTS:

Frank J. Jirka, Jr.

Philip G. Thomsen

COMMITTEE ON MENTAL HEALTH PS-11

1. The committee reviewed the "Resolution on Relations of Medicine and Psychology" as approved by the American Medical Association, the American Psychiatric Association, and the American Psychoanalytic Association and recommends its adoption. The resolution, which follows, defines "Psychotherapy" as a special form of medical treatment that should be selected for use according to medical criteria, and agrees that "psychotherapy" does not form the basis for a separate profession.

RESOLUTION ON RELATIONS OF MEDICINE & PSYCHOLOGY

For centuries the Western world has placed on the medical profession the responsibility for the diagnosis and treatment of illness. Medical practice acts have been designed to protect the public from unqualified practitioners and to define the special responsibilities assumed by those who practice the healing art, for much harm may be done by unqualified persons, however good their intentions may be. To do justice to the patient requires the capacity to make a diagnosis and to prescribe appropriate treatment. Diagnosis often requires the ability to compare and contrast various diseases and disorders that have similar symptoms but different causes. Diagnosis is a continuing process, the character of the illness changes with its treatment or with the passage of time, and that treatment which is appropriate may change accordingly. Recognized medical training today involves, as a minimum, graduation from an approved medical school, and internship in a hospital. Most physicians today receive additional medical training, and specialization requires further training.

Psychiatry is the medical specialty concerned with the illness that has chiefly mental symptoms. The psychiatrist is also concerned with the mental causes of physical illness, for we have come to recognize that physical symptoms may have mental causes just as mental symptoms may have physical causes. The psychiatrist, with or without consultation with other physicians, must select from the many different methods of treatment at his disposal, those methods that he considers appropriate to the particular patient. His treatment may be medicinal, or surgical, physical (as electroshock) or psychological. The systematic application of the methods of psychological medicine to the treatment of illness, particularly as these methods involve gaining an understanding of the emotional state of the patient and aiding him to understand himself, is called psychotherapy. This special form of medical treatment may be highly developed, but it remains simply one of the possible methods of treatment to be selected for use according to medical criteria for use when it is indicated. Psychotherapy is a form of medical treatment and does not form the basis for a separate profession.

Other professional groups such as psychologists, teachers, ministers, lawyers, social workers, and vocational counselors, of course, use psychological understanding in carrying out their professional functions. Members of these professional groups are not thereby practicing medicine. The application of psychological methods to the treatment of illness is a medical

function. Any physician may utilize the skills of others in his professional work, but he remains responsible, legally and morally, for the diagnosis and for the treatment of his patient.

The medical profession fully endorses the appropriate utilization of the skills of psychologists, social workers, and other professional personnel in contributing roles in settings directly supervised by physicians. It further recognizes that these professions are entirely independent and autonomous when medical questions are not involved; but when members of these professions contribute to the diagnosis and treatment of illness; their professional contributions must be coordinated under medical responsibility.

2. The committee also met informally with Dr. Harold Visotsky, Director of the Department of Mental Health, to give him their reactions to certain portions of his planned revision to the Mental Health Code. Since Dr. Visotsky was only seeking to determine how the committee might react to certain changes, the discussion was informal, and unofficial. It was understood that when the revision was introduced into the General Assembly, the ISMS Legislative Committee would seek specific recommendations from the Mental Health Committee concerning the final form.

3. In regard to the establishment of a statewide psychiatric case registry, the committee expressed strong reservations about the possibility of designing such a program that would not endanger the physician-patient relationship. Because the registry was only in the discussion stage, no action was followed.

4. With the resignation of Dr. Arthur Baker from the committee, the chairman nominated Dr. Ralph Naunton to fill the vacancy. This was referred to the Chairman of the Board of Trustees.

John R. Adams, *Chairman*

Walter H. Baer
E. Eliot Benezra
Louis D. Boshes
Irving Frank

Richard J. Graff
John H. McMahon
Robert A. Moore
Walter P. Plassman

Harold M. Visotsky

AUXILIARY REPRESENTATION:

Mrs. Thomas Turlentes

ILLINOIS DEPARTMENT OF MENTAL HEALTH PS-12

Although during the past year the Department of Mental Health has directed considerable activity toward the upgrading of treatment programs in existing facilities, the main thrust has been in the acceleration of its efforts toward the realization of a community mental health program which is organized on the com-

munity level, is community based, is community developed, and is community supported with provision for financial supplementation from state and federal sources.

The focus continues to be an emphasis toward primary prevention, early treatment, and sound rehabilitation with a goal of bringing each patient under the Department's care to his fullest operational potential.

The Department of Mental Health is treating more mental health problems of its citizens than ever before. With a new high in admissions to state mental hospitals in 1966—21,990 as compared with 19,890 the previous year—there was a 2,526 increase in discharges. Yet, despite the increased admissions, the resident patient population was reduced from 30,837 in 1965 to 28,322 in 1966. Department schools and centers for retarded had 9,808 residents in 1966, a reduction of 181 from 1965.

Public support for mental health is reflected in citizen assumption of financial responsibility for programs. In 1966, four of the five local tax referendums (under House Bill No. 708) were passed.

The Department of Mental Health has assisted both local communities and the federal government in the planning and administration of \$2,159,841 in federal construction grants under Public Law 88-164 for community services.

The number of employees in the Department of Mental Health reached 19,900 in 1966. The physician-patient ratio in the state hospitals has improved from one physician for 110 patients in 1962 to one physician for 69 patients in 1966.

State grants of more than \$4,000,000—an increase of more than \$500,000 in the preceding fiscal year—have been awarded through the Department of Mental Health for current fiscal year to 56 mental health clinics, 34 day centers for the mentally retarded, and to other community agencies.

Under individual care grants, the state is providing financial aid to a monthly average of approximately 500 Dixon and Lincoln State Schools' waiting list applicants.

Last year Illinois received more than \$12,000,000 in federal mental health grants for such purposes as hospital improvement projects, employee training programs, and implementation of planning for the mental retardation program.

During the past year, three additional zone centers were completed: H. Douglas Singer Zone Center, Rockford; John J. Madden Zone Center, Hines; and Adolf Meyer Zone Center, Decatur. The Charles F. Read Zone Center, Chicago, which was the first to be completed, opened in July 1965. The construction of the remaining zone centers at Springfield, Champaign, and Peoria will be completed by late spring.

Examples of some zone activities:

Rockford Zone—Of 90 persons treated in the Winnebago-Boone unit (of Singer Center) in the first two and one half months' operation, only seven had to be referred on for state hospital care; in the same period 12 months earlier, 71 patients were admitted to state hospitals from the Winnebago-Boone area. Also, the average length of stay at the new zone center has been only 21 days.

Chicago North Zone—Identification of high incidence (of mental illness) areas with a start in one of these areas to develop a comprehensive mental health program, along with making zone demonstration programs operational and focus upgrading existing facilities in the quality of care, including medical treatment, are efforts which appear significant.

Chicago South Zone—The first new direct care facility of the zone was opened at 1439 S. Michigan Ave., Chicago, on May 18, 1966. It is a 40-bed inpatient unit to receive and treat all patients coming from that portion of Cook County in Zone III who are referred to the department on emergency petition by the Psychiatric Institute of the Municipal Court of Cook County.

Peoria Zone—Zone staff has been working cooperatively with community agencies on such projects as the Peoria area alcoholism clinic, a Rock Island after-care recreation center, a family service clinic for Bureau County, and a combined campus-community mental health service at Western Illinois University, Macomb.

Springfield Zone—One of the last zones to become organized and one of the last to have its zone center completed, the Springfield zone has seen its nucleus staff concentrating upon administrative organization, staffing needs, program development, and community exploration.

Decatur-Champaign Zone—Highlighting community efforts of the zone staff was the development of an inpatient general hospital psychiatric service, staffed by general practitioners, at St. Anthony's Memorial Hospital in Effingham.

East St. Louis Zone—Without a zone center, considerable attention in this zone has been given to strengthening and upgrading services and programs at Alton State Hospital. Zone personnel have played an effective role in coordinating relationships between Alton State Hospital staff and Metropolitan St. Louis communities.

Carbondale Zone—Like the East St. Louis Zone, the Carbondale Zone does not have a zone center. One of the many laudable community endeavors is the Alexander-Pulaski County Counseling Center. Treatment services are being offered two days a week in Cairo, one day by staff members of the zone children's clinical services section and on a second day by staff members from Anna State

Hospital. An emergency telephone service has been set up in connection with this project.

A key department project is the refresher course for physicians, the planning for which in 1966 involved the Illinois State Medical Society. The first session of a series of three-day sessions—tentatively scheduled for sixteen consecutive weeks at the Illinois State Psychiatric Institute—began Jan. 26, 1967. Dr. Robert C. Drye, Director of Education for the Department of Mental Health, assisted by Dr. A. A. Kaluzny, Acting Chief of Medical Services, has major responsibility for the course. Faculty members are drawn from the medical schools in Chicago.

Primarily designed to prepare department physicians who hold Illinois temporary licenses for the Illinois Physicians and Surgeons Examinations, the course is open to physicians in the Department of Children and Family Services and the Department of Public Health. The present enrollment of 45 doctors represents Kankakee, Tinley Park, Manteno, and Elgin State Hospitals; Dixon State School; Fox Children's Center (Dwight); Mental Health Center and Illinois State Psychiatric Institute.

Perhaps one of the areas in which the Illinois State Medical Society can be of productive assistance to the Department of Mental Health is the one related to educating and informing society members about mental health programs, needs, resources, and cooperative endeavors.

Individual physicians can give invaluable service by following their patients into the mental facility, during their stay, and their follow-up care in the community. Physicians can be instrumental in integrating psychiatric services in community hospitals, with the provision that these hospitals plan cooperatively with medical staffs of other area hospitals to avoid duplication. Physicians should use the mental health centers extensively, and there should be more consultation between the family physicians and the centers.

With 95 percent of the mentally retarded living in communities, the Illinois State Medical Society has a responsibility, along with the Department of Mental Health, for meeting the needs of this non-institutionalized group. In addition to various community programs being developed in the zones, there still exists a critical necessity for additional residential facilities. Twenty million dollars is needed this biennium for mental retardation construction. Included would be a new 400-bed facility in Chicago to serve Cook County.

Among items of proposed mental health legislation for consideration by the 75th General Assembly are the following which may be of interest to the Illinois State Medical Society:

1. *Increased Appropriations*—Though funds for vital construction will be requested, the ap-

appropriations requests will reflect an emphasis upon personnel and personnel requirements.

2. *Construction Costs*—An amendment of present statutes authorizes grants-in-aid—not to exceed 30 percent of the construction and equipment costs—for local mental retardation and community mental centers. An appropriation of \$2,000,000 from the Mental Health Fund is provided.
3. *Payment for Private Care*—An item is being included in the department's General Revenue Budget to provide "treatment of indigent persons in private psychiatric facilities—\$2,000,-000."
4. *Narcotics Program*—Legislation is being drafted to amend statutory provisions of the Narcotic Advisory Council, of which the Director of the Department of Mental Health is the chairman (and of which Dr. Joseph Skom is a citizen member). The Commissioner of the Board of Health of Chicago and additional citizen members are being added. A biennial budget for a narcotic program will include funds for a two-year pilot program.

The Department of Mental Health sees itself as a vital and integral part of Illinois medicine—and, it is hoped this feeling is reciprocated.

Harold M. Visotsky, *Director*

COMMITTEE ON NURSING PS-13

1. The question of the legality of the Licensed Practical Nurse giving hypodermic injections was raised again this year because of divergent legal opinions on the subject.

At the request of the Director of Registration and Education, the Board of Trustees referred this to its Committee on Nursing for recommendations.

The Committee agree that ideally the following conditions should prevail:

- A. The L.P.N. should be permitted to give hypodermic injections where authorized by a physician unless specifically prohibited by individual hospital policy.
- B. The education of L.P.N.'s should include training in the giving of injections.

2. In certain specific cases the question of the point at which the practice of nursing ends and the practice of medicine begins again presented the need for some guide to the technical functions of nursing. Insofar as is possible, such a guide, would indicate to the physician which procedures he could reasonably delegate to a nurse.

To this end, the committee expects to devote some time on this project in the future.

3. The Illinois Study Commission on Nursing requested the cooperation of ISMS in preparing a questionnaire on office nursing for distribution to all members of ISMS. The purpose is to de-

termine the numbers, types, functions of and requirements for health personnel in physician's offices.

The results of this survey will be of great aid to the Illinois Board of Higher Education in planning to meet the future personnel needs of medical practitioners.

The form was sent to the ISMS members as soon as approval was obtained.

4. In discussing further development of a statement of the dependent functions of nurses the committee reaffirmed its approval of the INA statement of Dec. 20, 1965. It expressed a desire to conduct a follow-up of the Illinois hospitals to see what implementation had resulted. Mr. Boeck was instructed to write 25 hospitals in four categories (less than 50 beds, 50-100 beds, 101-300 beds, and more than 300 beds) and see if any action was taken and if so, request copies of the policies.

Because of the desire in some areas to eliminate the diploma schools of nursing, the committee wanted to go on record with a statement favoring the retention of these schools in Illinois. The following was adopted and recommended for Board endorsement: "The diploma school of nursing plays an important role in providing nurses for the bedside care of patients and should be encouraged to continue to fulfill this role as long as there is a need for this type of educational institution."

W. I. Taylor, *Chairman*

T. J. Conley	Henrietta Herbolsheimer
Angelo P. Creticos	H. J. Kolb
J. D. Heath	Nicholas P. Primiano

CONSULTANTS:

Ted LeBoy	W. C. Scrivner
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COMMITTEE ON NUTRITION PS-14

1. This year the committee again sponsored two conferences, one in conjunction with the Illinois Nutrition Committee and one with the Chicago Nutrition Association and the Chicago Section of the Institute of Food Technology.

The Symposium on Nutrition and Food Technology, in Chicago, was on "World Food Problems—Challenges and Opportunities". About 175 persons attended this meeting to hear eight eminent specialists. The success of the program led the joint sponsors to request a similar effort in 1968.

The second conference, in Quincy, attracted 150 dieticians, home economists, physicians, and others interested in nutrition. The evening session was combined with the regular meeting of the Adams County Medical Society and brought out a good representation of doctors.

Plans are underway for the 1967 conference which will probably be in Bloomington or Normal.

2. The chairman represented ISMS at a meeting called by the Department of Public Health to discuss a mastitis control program. As a result of this the Board of Trustees approved a statement commending the Illinois dairy industry for its efforts to improve the quality of their products and pledged support of the mastitis control program.

3. The committee also met with Dr. Alfred D. Klinger, sponsor of Resolution 66M-40, at the request of the 1966 House of Delegates. Dr. Klinger's resolution called for an increase in the food allowance for public aid recipients.

Dr. Klinger brought guests to substantiate the claim that the 20 cents per meal per person allowance is inadequate to sustain good health.

It was Dr. Klinger's opinion that the present emergency diet be changed to the USDA "moderate cost diet" which requires 33-35 cents per meal per person.

Recognizing that there are other factors involved but limiting itself to the nutritional aspects of the problem, the committee voted to support the resolution and ask the House of Delegates to authorize a request to the Illinois Department of Public Aid to increase the allowance to meet the USDA "moderate cost diet".

4. The committee was also approached by the Milk Foundation concerning the presentation of a nutrition conference in the Spring of 1967. Because the foundation was interested only in the Chicago area, the committee decided not to become involved.

Paul A. Dailey, *Chairman*

Paul R. Cannon

John B. Hall

Fred C. Endres

Harvey D. Scott

COMMITTEE ON PERINATAL MORTALITY

PS-15

The Committee on Perinatal Study was established in 1962 and as an outgrowth a pilot study has been carried out over the past three and one-half years. Of prime concern was the significant difference in perinatal mortality in various counties and sections of Illinois, and the apparent failure of the medical profession to continue lowering the perinatal mortality rates in Illinois in the past 15 years. On a purely voluntary basis, we have received reports of about 900 perinatal deaths from participating hospitals in 11 counties across the central portion of Illinois. These infant deaths have been studied by the sub-committee on fetal deaths in regard to:

1. Cause of Death
2. Preventability
3. Responsibility

The great mass of these deaths were unavoidable disasters, due to congenital anomalies incompatible with life, or due to intercurrent disease. In about 5.5 percent of the deaths, however, we believe better

medical management would have altered the outcome.

The committee feels that the pilot study has served its function and in as much as the number of case histories reported seems adequate and the reported tendencies seem uniform, we feel the pilot study should be discontinued.

Therefore, as we respectfully request permission to discontinue this pilot study, we again encourage participation in a statewide study that would illuminate the areas where medical seminars or other methods of voluntary education programs would serve to improve the medical standards available.

Leo G. Perucca, *Chairman*

William W. Curtis, *Co-Chairman*

Paul A. Dailey

John H. Rendok

Velma Foresman

Simon Y. Saltman

Robert R. Hartman

Eugene L. Slotkowski

Harry L. Lewis

Walter G. Steiner

Donaldson F. Rawlings

John A. Taft, Jr.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH PS-16

Dental Health: A different approach to providing dental care and dental health education to children in low income families and families of migrant laborers has been initiated by the Department. During 1966, a mobile dental unit was developed for use in a statewide program. During the summer months, the unit traveled to migrant labor camps and the dentist in charge of the mobile "dentist's office" provided on-the-spot care to the children. During the school year, the unit has been visiting schools upon request and providing dental care to children who otherwise would not receive it.

Many patients who do not call on their physician until they are ill, see their dentist routinely for check-ups. It is recognized that the dentist is in a unique position to examine the patient's mouth where early symptoms of some diseases may be manifest before the patient is aware of any illness. Indications may point to oral cancer, leukemia, vitamin deficiencies or other diseases. Early recognition of these signs with referral to physicians is part of a graduate professional education effort in the Department.

Foods and Dairies: Toward the end of 1965, the Division of Foods and Dairies was transferred from the Department of Agriculture to the Department of Public Health. One of the changes instituted was a modification of procedures involved in the statutory requirements for semi-annual physical examination of food handlers at wholesale and retail dairy plants. These have been revised so that emphasis has been changed from a former requirement of routine serological tests for syphilis and smears for gonorrhea to concen-

trating on history and signs for symptoms of enteric disorders, purulent skin lesions and other disorders related to food-borne diseases. In the formative state is a proposed state law requiring annual licensing of food service establishments. This will aid those areas where adequate municipal or county authorization for licensing is absent.

A number of in service training seminars for inspectors and sanitarians have been conducted in cooperation with state and federal agencies.

Preventive Medicine: Agricultural migrant workers are essential to the economy in Illinois. As most of them are indigent they lack adequate medical and health services of good quality. Current health services provided through the department include hospital care, and out-patient, pre- and post-natal care for maternity patients; pediatric care including hospital and out-patient services when required, medical care by a physician, public health nursing, dental treatments, immunizations, vision and hearing screening, and tuberculin testing. A bill has been introduced into the 75th General Assembly to make these services available to other migrant laborers besides pregnant mothers and children.

A pilot study is being conducted, whereby parent-administered vision screening cards are given to parents by the pediatricians of preschool patients in an effort to detect amblyopia ex anopsia early enough to institute corrective measures before entering school. These cards are furnished by the department in a joint effort with the Illinois State Medical Society and the Illinois Chapter of the American Academy of Pediatrics, to determine the effectiveness of this approach.

The PKU program has been in operation for over a year. The department is exploring the implementation of a recommendation by the Child Health Committee of the Illinois State Medical Society, where increased follow-up of diagnosed cases will be performed jointly with the Illinois Division of Services for Crippled Children. In addition, pilot studies of screening tests for cystic fibrosis and histidinemia are under consideration.

Hospitals and Chronic Illness: A major activity of the department has been the implementation of the Medicare program as it pertains to approving hospitals and extended care facilities for certification. Of a possible 314 eligible hospitals, 293 have been certified to participate in the Medicare program. Since July 1, 1966, 81 (of 108 applicants) home health agencies were certified. The department sent 815 applications to potential providers of extended care benefits. Of this number, 289 elected to participate and of the 289, 108 have already been certified. Of these, 84 were nursing homes, 13 infirmaries in homes for the aged, and 11 were hospital-related extended care facilities.

At the 1966 annual meeting of the Illinois State Medical Society a recommendation was made that the health and medical aspects of Title 19 (Medicaid) be transferred from the Department of Public Aid to the Department of Public Health. A letter to this effect was sent by the Illinois State Medical Society to the Governor and at subsequent meetings of the society this intent has been reaffirmed. Currently, proposed legislation to implement this is under consideration.

Tuberculosis Control: Modern drugs and care have shortened the hospitalization time necessary for tuberculosis patients. There is now a great need for clinic facilities for the patient after he leaves the hospital. Studies made during the past year indicate that establishment of additional out-patient clinic facilities may be made possible by using some of the funds which are keeping available almost 1,000 empty beds in the existing local and state tuberculosis hospitals. This means is under consideration.

Legislation: There is a considerable amount of new legislation being introduced into the 75th General Assembly that involves responsibilities of the department that will be of interest to, or that will require cooperation of Illinois physicians. Most of these will be described elsewhere. They include bills to study air pollution problems; to register and regulate refuse disposal sites; to decrease the level of blood alcohol (from 0.15 mg. percent to 0.10 of alcohol in the blood) at which a presumption of intoxication exists; to license and regulate ambulances and ambulance drivers and attendants; to prohibit narcotic addicts from driving motor vehicles; to amend the school code so that the Board of Education will designate the physician to give physical examinations to its employees, and others.

Among proposed legislation giving additional activities to the department that would involve a close correlation with the Illinois State Medical Society is the Illinois Drivers' License Medical Review Act. This act calls for the establishment of minimum physical and mental standards for determining a person's ability to operate a motor vehicle safely. Such standards would be established by the Department of Public Health with the aid of a medical advisory board. The legislation would also include authority for establishing a medical board of review within the department. A related bill would amend Section 6-207 of the Illinois Motor Vehicle Law to permit the Secretary of State to require physical examinations in certain instances and to have reports of such examinations forwarded to the state Department of Public Health by the person making the physical examination.

Nursing: The Department has made special efforts to help communities develop home health services. Thus, when a physician sends a Medicare

patient home he would be in a position to prescribe home nursing and other health services. With the encouragement of the department, 34 counties have formed a health department by resolution, primarily in order to provide home health services. Of these, 23 are now certified. In addition, 30 counties having previously organized health departments, two city health departments, and 25 visiting nurse associations are now providing home nursing services.

Close ties between physicians and boards of health or public officials who approve the development of health departments will be needed if medical guidance is to be built into the services of these community agencies. Likewise, enlightened physician support of proper national and state legislation and appropriations for health organizations and health services will be even more important in the future than in the past.

Sanitary Engineering: Public hearings were held throughout the state in order to establish water quality criteria for interstate streams. Stream standards were adopted by the Sanitary Water Board and have been submitted to Federal authorities for their approval. During the past year, six municipalities and 15 industries were cited by the board and referred to the Attorney General for legal action. In addition, 10 hearings were held to resolve pollutional problems without recourse to the courts.

Radiological Health: There are now 8,154 installations registered with the Department, which includes 1,310 physicians, 4,510 dentists, 420 chiropractors, 330 industries and 318 hospitals. Among other sources of radiation at these installations there are 10,801 x-ray machines of all types. Under the Radiation Monitoring Act, the department is receiving radiation exposure information on approximately 2,000 persons quarterly. By Jan. 1, 1967, there were 25,000 quarterly reports on the department's central registry. A spot check of the information on the registry reveals that the arithmetic average quarterly exposure is 183, 150, and 122 millirems for industrial workers, physicians, and hospital employees respectively. The Department has requested that all known commercial film badge services meet the minimum performance standards under the National Sanitation Foundation's Film Badge Standard #16, by July 1, 1967. The Department has accepted title to 20.4 acres of land in Bureau County that is to be used for the burial of radioactive waste. A contractor has been selected to operate this site for the state. Recently announced nuclear facilities to be constructed in Illinois include nuclear power stations to be located near Cordova, Zion, the expansion of the Dresden Nuclear Power Station, and a nuclear fuel rod reprocessing facility.

Franklin D. Yoder, *Director*

COMMITTEE ON RADIATION SAFETY PS-17

At the request of the State Department of Public Health, a meeting was called to review current laws, rules and regulations, governing the use of radium in Illinois. This was prompted by a USPHS recommendation that the use of radium be discontinued in favor of other radioactive substances.

Because of the medical implications of such a recommendation, and the unwillingness of some physicians to agree that radium should be eliminated from their practices, a sub-committee, headed by Dr. Ernest Breed was appointed to study the matter more closely. This sub-committee met to prepare statements on the medical uses of radium and proper methods of safely handling it.

The following report was submitted to the committee and approved:

Problems:

1. State Health Department's strict enforcement of regulations on:
 - a. Handling of radium.
 - b. Exposure to patients adjacent to one under treatment.
 - c. Leaking sources.
 - d. Contamination problems.
 - e. Responsibility for leak testing.
2. Definition of "Hazard to public health."
3. Advisability of indirectly forcing change from radium to other sources through harassment.

Factors for Consideration:

1. From long usage the effectiveness of radium in the treatment of certain diseases is unquestioned, while newer isotopes are still in the process of evaluation. Since gamma rays from radium have a variety of energies and the proposed replacement elements have monochromatic energies it might well be that they cannot replace radium in all its uses. It is reasonable, therefore, that a change over, if desirable, should be delayed until the replacement elements are fully proven.

2. While all irradiating sealed sources are subject to leak and to loss, it is conceded that the leak problem with radium is greater than that of the isotopes but dangers from all such sources, radium included, can be controlled by care. Dosage errors in therapy are less likely with radium because of its constant strength than with the shorter half life elements.

3. It is unwarranted to deny or make difficult life preserving radiation to a patient suffering with malignant disease because of some remote possibility of injury to others.

4. There are many radium sources in medical use in the United States. The accidental fracture of a medical source capsule with loss of radium

salts is known to have occurred only a few times. As far as we know, no serious injury to anyone has been recorded in the literature.

5. While it is true that many radium tubes have developed radon leaks, the ill effects to personnel has not been demonstrated. With frequent leak testing of all sources this possibility can be easily controlled.

6. While fixed radium "D" (lead 2-10) may be dangerous if ingested in sufficient quantities, the same may be said of nearly everything with which we come in contact. To demand the disposal of all objects contaminated with fixed lead 2-10 is unreasonable.

7. While the expertise of radiation physicists and radio-biologists is fully recognized and their suggestions should be adhered to as nearly as possible, public health embraces the lives and health of the people as a whole and rules should be realistic enough to permit physicians to do the best for their patients, having due regard for the rest of the community.

8. There have been cases of legitimate differences of opinion of highly qualified persons with regard to the realism of the recommendations made by the Illinois Department of Public Health inspectors. At present, no feasible method of review exists.

Recommendations:

1. Require periodic leak testing of all sources containing radioactive elements to be the responsibility of the owner in all cases.

2. Fixed lead 2-10 should be disregarded in a controlled area.

3. To permit the free use of radium if the patient is in a private room and if the source is employed in accordance with accepted therapeutic techniques.

4. Until such time as substitutes for radium are fully proven equal or superior, the use of radium should be facilitated.

5. That the Illinois Department of Public Health establish a Review Committee composed of two radiotherapists, one diagnostic radiologist, one hospital radiation physicist, one specialist in nuclear medicine and one dentist to consider problems that arise with the use of ionizing irradiations in medicine.

H. C. Burkhead, *Chairman*

J. Ernest Breed
Abram H. Cannon
Stephen L. Casper
Carl E. Clark
Robert W. Donnelly
James H. Geist

John R. Hartman
Stuart P. Lippert
James J. Nickson
Hyman R. Osheroff
Norman R. Shippey
Raymond B. White

COMMITTEE ON TUBERCULOSIS PS-18

In view of the difference of opinion concerning BCG vaccine, the committee reaffirmed its position taken in 1963 and seeks House of Delegates approval of the following statement:

"Widespread BCG vaccination in Illinois, including Chicago, is contra-indicated today because it interferes with the use of the tuberculin test as a epidemiologic and diagnostic tool".

It was pointed out that this view was in accord with that of the USPHS.

The committee also strongly endorsed the recommendations of the Governor's Advisory Committee, with special emphasis on the continuing need for diligent case-finding and follow-up work in areas where tuberculosis sanatoria are closed and inpatient services are no longer required.

The points of this report are:

1. Broadening the state subsidy to qualified local governments for including out-patient clinical and follow-up services, as well as sanitarium care, for tuberculosis patients.

2. Providing for the orderly closing of tuberculosis sanatoria in areas where in-patient care is no longer considered necessary, transferring of physical plant and equipment to appropriate agencies, and establishing diagnostic and follow-up care on an out-patient or clinic basis. It is contemplated that this legislation be drawn to avoid the necessity for a referendum.

3. Prescribing uniform residency requirements for dispensing tuberculosis patient services in Illinois.

4. Creating permissive legislation for various health agencies to co-operate in providing out-patient clinical and follow-up services to tuberculosis patients.

5. Setting up minimum standards for out-patient clinical and follow-up services to tuberculosis patients.

In one further action, the committee also endorsed in principle the proposed survey and evaluation of chest clinics proposed by the Illinois Association of Sanatorium Boards and requests the House of Delegates to take similar action.

Charles K. Petter, *Chairman*

Otto L. Bettag

Kenneth G. Bulley

John C. Devlin

Charles W. Gray

Clifton Hall

Hiram T. Langston

David F. Loewen

Karl H. Pfuetze

William P. Standard

George C. Turner

CONSULTANTS:

William E. Adams

Darrell H. Trumpe

E. A. Piszczek

JOURNAL COMMITTEE PS-19

A number of significant changes and developments are noteworthy of reporting to the membership by the Journal Committee in this 1967 annual report. These include adoption of several proposals made by the staff and acted upon favorably by the Journal Committee and board concerning the *Illinois Medical Journal*, *Pulse*, and *What Goes On in Illinois*.

First, it is a pleasure for the chairman to report that the net income from advertising the past year far surpassed that of each of the last six years. In the preliminary financial statement, issued Dec. 31, 1966, *Journal* net income was \$100,379.83—an increase of \$23,000 over 1965, and 15 percent above the projection for the fiscal year.

The cost of producing the *Journal* in 1966 rose to \$119,000, reflecting increases during the year in printing costs, paper and servicing advertising accounts. This figure, however, includes approximately \$3,000 paid for paper that will be used in 1967. (Paper is purchased in large quantities to obtain savings by "bulk" lots.) Printing and paper costs increased approximately 10 percent over 1965 along with the slightly larger size *Journals* published in the latter months of the year. Also, four-color process printing of advertisements that began with the September issue and continued through December raised overall publishing costs. More of these ads are scheduled for 1967, but income from the four-color work will more than offset the additional costs involved.

We should again be cognizant that if the full amount of the dues dollar allocated to the *Journal* on a pro-rata member basis was used (\$2.50 per member per year), the *Journal* would have shown a modest profit in 1966. Since this was unnecessary, *Journal* income relieved pressure on the society's operating fund the past year.

Among the proposals made by the *Journal* staff and adopted by the committee and the board in 1966 were:

1. Adoption of the new and larger *Journal* format effective with the January, 1967, issue. IMJ's trim size is now 8 x 11 inches and conforms with that of the majority of state medical journals and many other national medical publications. The new size is expected to be helpful to advertising agencies and pharmaceutical firms and IMJ in the preparation of standardized advertising plates and printed inserts.

2. An increase of 15 percent in advertising rates effective with the January, 1967, issue was approved. The new rates will increase *Journal* revenue in 1967. With the addition of several new accounts and a higher volume of advertising by firms who have been with us faithfully

throughout the recent advertising "depression" years, the *Journal* income is expected to continue its favorable upward trend. Mr. Charles L. Baldwin, our eastern advertising representative, should be commended for his efforts in assisting Mr. Kinney, business manager, in this direction.

3. Because of the changeover to the new *Journal* format beginning January, 1967, our former printer, Service Printers, Inc., advised Mr. Boeck that a rather substantial increase in production costs per issue could be expected. This was based on the type of equipment available at Service Printers to print the *Journal*. After a number of meetings with Mr. Boeck and staff on the problem and a discussion of the proposal of Neely Printing Co., our printer before the switch-over to Service Printers a year or so ago, the Journal Committee recommended a return to this printing company. Neely's competitive bid and past performance were decisive factors in awarding the contract on a year's basis.

It is appropriate also to explain the establishment of a new "Publications and Illinois Medical Journal Division" to function as a separate entity, budget-wise, under the original division of "Publications and Scientific Services" headed by Mr. Al Boeck. The publication sub-division is designed to improve management, staffing and auditing procedures. Mr. Boeck will retain his supervisory role over the new sub-division with the assistance of Mr. John Kinney, who continues as its Assistant Director and Business Manager with primary responsibility for publication of the *Journal*. Mr. Perry Smithers is now serving as Editorial Manager and Assistant Editor of the *Journal*. At the end of the year, Miss Donna Laham was hired as secretary for the Journal Department. Mr. Smithers' appointment to the *Journal* and his new duties in the division were approved by the committee and the board in December, 1966. He will also continue to edit the *Pulse* and *What Goes On in Illinois*. To assist him with his additional duties, Mrs. Anita McLaughlin has been employed as typist.

Members interested in seeing how the new sub-division of "Publications and Illinois Medical Journal" is budgeted and structured financially in the 1967 operating budget of the society may have copies of the budget on request. As previously mentioned, this organizational change is primarily for efficiency and auditing, and reflects no cost increases.

Financial arrangements for publishing the *Pulse* and *What Goes On in Illinois* have been renewed for 1967 by Roche Laboratories Division, Hoffmann-LaRoche & Co., Nutley, N. J., and Lederle Laboratories Division, American Cyanamid Co., Pearl River, N. Y., respectively. Both publications, incidentally, are cost-free to the so-

ciety. The committee and the board believe these publications serve the membership usefully and well. Our appreciation is extended to these pharmaceutical firms for providing the grants for the editorial preparation, production and distribution of these publications to the ISMS membership, Woman's Auxiliary, public relations and news media locally and nationally.

4. Progress is also being made on development of a Drug Product Evaluation and Consulting Board. The board consists of 112 members of our society, representing 22 specialties, who have accepted an invitation to participate in specialty panels. The services of this unique board will be offered to select pharmaceutical firms on a consulting fee basis. More details on the activity of the consulting board will be available at convention time and reported to the membership.

As in past years, this report would not be complete without the Journal Committee's highest commendation of the *Journal* staff, Mr. Al Boeck, Mr. John Kinney, Mr. Perry Smithers and their assistants. These dedicated individuals are now beginning to see the fruition of their ideas and ideals of several years of experience with the IMJ, and a brighter horizon ahead from the problems and frustrations during the lean years of advertising media participation. The Journal Committee urges this staff to be progressive, evolutionary and responsive to current changes so as to produce the nation's outstanding state medical journal.

Jacob E. Reisch, *Chairman*

J. Ernest Breed

Frank J. Jirka

William M. Lees

Darrell H. Trumpe

EDITORIAL BOARD

PS-20

The Editorial Board met on June 8 at the request of the Journal Committee to consider a special project involving some 16 papers that had been presented at the ISMS Narcotics Conference. The Narcotics Committee had expressed a desire to have all the papers published together, and the Journal Committee referred the matter to the Editorial Board.

The manuscripts were distributed to members of the Editorial Board prior to the meeting and each paper was reviewed by at least two members of the board. After discussion of the individual papers, the collection as a whole was evaluated.

In general, the papers were considered excellent in content although some were in need of editing and condensing. Drs. Texter, Kowalski, Mueller, Kravitz, Falls and Webb volunteered and were appointed to help prepare them for publication. Dr. Texter served as guest editor.

The collection was included as a special section in the October IMJ and reprinted. Many

favorable letters from physicians and others concerned with the narcotics problem were received.

In the opinion of the Editorial Board, IMJ is continuing to present articles of merit and is maintaining its status as one of the outstanding state medical society publications.

Samuel A. Levinson, *Chairman*

Edwin F. Hirsch

C. J. Mueller

James H. Hutton

Jacob E. Reisch

Julius M. Kowalski

Frederick Steigmann

Harvey Kravitz

E. Clinton Texter, Jr.

Charles Mrazek

Arkell M. Vaughn

EDITOR

ILLINOIS MEDICAL JOURNAL

PS-21

During the past 12 months the Journal staff has been plagued with a series of resignations and illnesses. Our assistant director, John A. Kinney, has been ill for several months, but I am happy to report that he has made a successful recovery and will be back in the saddle by the time this report appears.

In the past year we published 57 clinical articles, nine medical progress articles, 28 editorials, 31 book reviews, 18 socio-economic articles, 26 excerpts, and 17 papers presented at the Illinois State Medical Society's Conference on Narcotics Addiction. In addition, we published a monthly message from the president, Paul de Haen's monthly listing of New Pharmaceutical Specialties, and Dr. Leon Love's View Box.

In September we began publishing Surgical Grand Rounds, case reports from Chicago Wesley Memorial Hospital, Passavant Memorial Hospital, and the Veterans Research Hospital.

In accordance with findings of the Opinion Research Survey, the society is taking steps to increase communication with its members. As part of this program, Mr. Perry Smithers was assigned to the Journal staff as Assistant Editor to help with the diversified editorial content as well as coordinate it with the society's other publications, *Pulse* and *What Goes On*.

T. R. Van Dellen, M.D.

Editor

COMMITTEE ON SCIENTIFIC

EXHIBITS

PS-22

The committee solicited and reviewed applications for scientific exhibits for the 1966 convention and accepted 26.

The awards committee, after careful review, selected the following winners;

Exceptional Educational Value

Gold Award: "Bone Scanning with 85-Strontium and its Clinical Applications" by Rafael M. Garces and Robert Carlin, of Evanston Hospital and Northwestern University.

Silver Award: "The Surgical Treatment of Stroke" by Isa Sejdinaj of Sherman Hospital and St. Joseph Hospital, Elgin

Bronze Award: "Clinical and Experimental Aspects of Motor Nerve Conduction Velocity" by D. I. Abramson, L. S. W. Chu, S. Tuck, Jr., S. W. Lee, G. Richardson and M. Levin, of the Department of Physical Medicine and Rehabilitation, University of Illinois.

Most Original Work

Gold Award: "Ultra-Sound Diagnosis—Theory and Practice" by Lothar Hussman, H. W. Krenast, and Louis D. Boshes, of University of Illinois.

Silver Award: "Adjuvant Therapy in Ocular Trauma Sequel" by Robert H. G. Moninger, of the Department of Ophthalmology, Stritch School of Medicine.

Bronze Award: "Photochromogenic Mycobacterial Pulmonary Infection in Chicago" by Y. Takimura, M. R. Lichtenstein, and J. R. Thompson of the City of Chicago Municipal Tuberculosis Sanitarium.

For the first time, the committee presented the Aesculapian Award, sponsored by Mead Johnson Co. for an outstanding exhibit. It was awarded to E. R. N. Griggs, Cook County Hospital, Radiation Center, for "Historical Synopsis of American Radiology."

Ten movies were continuously shown each day and were attended. Plans for the 1967 Convention started early and applications were being reviewed at the time this report was submitted.

Coye C. Mason, *Chairman*

Raymond Firfer Franklin Lounsbury
Joseph J. Kozma Charles P. McCartney
Lawrence W. Peterson

COMMITTEE ON SCIENTIFIC ASSEMBLY PS-23

1. The committee met with the Section Chairman on Sept. 14, 1966, to work out the schedule for the 1967 Convention. This was done to the satisfaction of the sections, and the committee agreed to add programs by the Chicago Medical School and the Mid-West Chapter of the National Hemophilia Foundation.

2. The theme "Bettercare" was adopted for the convention and all sections were encouraged to plan their programs around this theme.

3. At Mr. Boeck's request, approval was given to increase the rates for technical exhibits to cover raises in production costs.

4. The Medical Exhibitor's Association ratings of the 1966 convention were reviewed and compared with those of previous years. A summary of these follows:

CLASSIFICATION OF MEETING

GOOD OR VERY GOOD

1961	21%
1966	78%

PHYSICIAN INTEREST IN EXHIBITS

GOOD OR VERY GOOD

1961	53%
1966	63%

RECOMMEND EXHIBITING NEXT YEAR

1961	60%
1966	90%

5. To expedite the work of the House of Delegates, the Camp Memorial Lecture has been rescheduled this year and will be combined with the Public Affairs Dinner on Monday night. The Committee on Public Affairs accepted the responsibility for obtaining an appropriate speaker.

6. Those portions of the Opinion Research Corporation's survey pertaining to the convention were reviewed and the committee expressed the opinion that the convention is rated quite well by the members.

Considerable room for improvement remains, however, and efforts will be made to make the meeting even more attractive in the future.

R. T. Fox, *Chairman*

John T. Brosnan Harold P. McGinnes
R. R. Fahringer Robert G. Page
William M. Lees Dale S. Raines
Charles P. McCartney J. Robert Thompson
Donald L. Unger

AUXILIARY REPRESENTATION:

Mrs. Wendell F. Roller
Mrs. Michael G. Maitino

COMMITTEE TO STUDY THE CONVENTION PS-24

In a continuation of its efforts to improve the ISMS annual convention, the committee met and submitted the following recommendations to the Board of Trustees. These were approved.

1. The committee reviewed the House of Delegates' comments on its efforts to achieve a merger of the Chicago Clinical Conference and the ISMS Convention. After discussing this, the committee decided to inform the ISMS Trustees of its inability to obtain any action from CMS and to suggest that the matter be discussed by the two boards of trustees. It was suggested that ISMS request an official statement from CMS concerning the advisability of continuing to work out a merger plan. The answer from CMS was that it does not believe a merger feasible at this time.

2. In striving to attract more members to the convention, the committee recommended that the trustees instruct the Committee on Scientific Assembly to investigate the possibility of conducting in-hospital post-graduate courses during the convention. These "wet clinics" have been successful in other areas and have been supported by a registration fee. It was suggested that each course be limited to as few as five registrants and that each be held in one of the major teaching hospitals in Chicago.
3. As a means of reducing the number of competing meetings and develop larger audiences for those meetings scheduled, the committee recommended that the specialties avoid non-associated topics by constructing the entire meeting around a theme. It felt that such an arrangement, with subjects connected with each other, would be of interest to larger numbers of members.
4. For future planning, the committee requested the Board for permission to investigate the possibility of holding joint conventions with one or more adjacent state medical societies.

George F. Lull, *Chairman*
 E. Chester Bone H. Marchmont-Robinson
 Norman E. Powers

CONSULTANT:
 William M. Lees

ILLINOIS JOINT COMMITTEE ON SCHOOL HEALTH PS-25

This report is primarily a report of the activity of the representative from the Illinois State Medical Society to the Illinois Joint Committee on School Health. There will be some other activities mentioned in which the representative has been involved, that are not necessarily a direct connection of the Illinois Joint Committee on School Health, but are indirectly related to it.

The Illinois Joint Committee on School Health met in its annual meeting May 7, 1966, at St. Nicholas Hotel, Springfield. One of the subjects discussed and acted upon, among various other subjects, was the problem of medical self-help. It had been brought out by the Superintendent of Public Instruction that they had informed school administrators that a 24-hour self-help course be taught at the senior level in high school. It was recommended that one hour be taken from health, physical education, and drivers' safety to promote this program. There was a reaction among school administrators in which some of

them at least were in a dilemma as to how they were going to include this into the curriculum.

The arguments presented were of course that it repeated much of what is now taught in Red Cross courses, the course causes problems with current curriculum set-ups, and the course was designed for adults and needs to be revised if it is to be used in schools. The kits for this particular program were made up by the Civil Defense Authority which were for adult consumption. Since the promotion of this program by the Civil Defense Authority in adult education had not received the response they had hoped for, they had hoped that by getting it to the high school seniors they would have an audience that couldn't escape it, therefore, could get the material to students who soon would be adults. This kit had been approved by the American Medical Association, but I am not quite sure that it had been recommended that it be put into the high school program. However, there was much discussion by administrators and physical education people and one determined school nurse, it was moved that the Joint Committee on School Health advised that this medical self-help course be taken out of the school curriculum and placed back in adult education, and the motion was seconded and carried.

This particular motion was brought to the Office of the superintendent of Public Instruction, Illinois Department of Health, caused considerable consternation inasmuch as they thought it had been approved by the medical society and all concerned, such as the Illinois Department of Health, Superintendent of Public Instruction, and the Department of Civil Defense, and various other agencies; therefore, there was called a meeting on Sept. 23, in Springfield in the State Office Building, to discuss this particular resolution which had been passed by the joint committee. It was brought out, in the discussion, that the Department of Civil Defense had hoped that this could be done because it was maybe not a captive audience, but an inescapable audience where they could get the material to the seniors in high school who would soon be adults and the Department of Instruction had recommended this particular kit that had been made up for adult consumption.

Inasmuch as I am chairman of the Joint Committee on School Health, I was called in to attend this meeting and discussion. It became rather obvious that the Department of Public Instruction and the Department of Public Health had not screened the kit together, and that the recommendation and discussion from the joint committee regarding revision of the kit for high school consumption was probably needed, and that there should have been a little more liaison between the two departments before the

recommendation was sent to the school administrators.

I, myself, was sort of in a dual position inasmuch as I am a physician and aware that it has been recommended by the AMA that self-help courses be taught primarily to the adult as a part of adult education, whether specifically the AMA had recommended it to the 12th grade or not I am not clear on the subject. However, as chairman of the joint committee I had to more or less reveal to them how the resolution came about and what division of people were opposed. Of course, it develops down to the simple fact that this is another item being shoved into the curriculum planning of schools and administrators just don't know where to put it. School takes up at 8:30 in the morning and dismisses at 3:22 in the afternoon which has a jammed curriculum and this is an additional thing to be worked in and some of them were, of course, in a dilemma. The school administrators, some school health nurses, and particularly physical education people were against the recommendation and about all I could say in defense of it was to relate how it happened. However, at the close of the conference on Sept. 23, it was decided that the Office of the Superintendent of Public Instruction and the Department of Public Health should get together and develop a workable kit for this subject in which the language would be understood, whether it will be much different from the adult kit, I am not sure. I made the suggestion to the group that maybe the school day should be extended in length. This, of course, did not fall upon receptive ears.

The Executive Committee of the Joint Committee on School Health met on Nov. 30 and this problem was then reopened for discussion. Incidentally, representatives from the Health Department of the Department of Registration and Education had been asked to attend. However, they acknowledged the invitation but both expressed that they had other commitments. After reviewing my report to them concerning the meeting with various representatives of the various agencies that were promoting the medical self-help program which was developed by the Civil Defense Authority, it was considered that it was now up to the schools to decide on an individual basis whether they wished to include self-help in their school and how this should be best accomplished.

Among other things considered at the Nov. 30 executive committee meeting was the "Emergency Care Guide" distributed by the Illinois Department of Public Health. The Office of the Superintendent of Public Instruction has printed 10,000 more copies. The general basis for distribution for the schools is two copies for every 250 children.

Another discussion concerned an orientation conference for recently employed school nurses which had taken place in the summer. This was a successful conference with 126 participants, and it was necessary to turn away 50 nurses because of space and inconvenience. There will be another workshop the last week of June and it will be financed by the Office of the Superintendent of Public Instruction. Representatives from the Illinois Association of School Nurses and the Illinois Nurses Association will attend this workshop. The present problem is that nurses without any previous training in child health or school nursing have been employed by school boards. The only qualification that some of them have is the fact that they are registered nurses, and they vary greatly in age and in recent nursing of any kind.

Sex education in reference to health is a very touchy subject and leads up to the primary subject of sex education in schools which is the basis of the Fourth Conference on Physicians in Schools in the State of Illinois, which was scheduled for the morning after this executive committee meeting.

The conference convened at 9:15 a.m. on Thursday, Dec. 1, 1966, and the theme chosen for the conference, "Coordinating Related Disciplines for Programs of Sex Education—Family Living." This conference was well attended, even though we had a restricted roster as far as registration was concerned. The highlight of the program, of course, was the keynoter, Dr. William Graham Cole. The program was well attended—some 275 people present, representing school nurses, nurses association, public health nurses and public health people, including school physicians and administrators in health education.

On Aug. 14, 1966, the Second Annual Athletic Injury Clinic was held at the University of Illinois Skating Rink, at which there were approximately 200 in attendance which included physicians, high school administrators, high school coaches and trainers. This was a good variety program. There were some things that weren't quite as interesting as others, but the phases on orthopedic and neurological injuries were very good and the presentation made by Dr. McCloskey of Urbana was especially good. A review of the questionnaire that those attending completed, indicated intense interest and that it was their opinion that the clinic should be repeated again next year. At the time of this report, the program committee is in the process of developing a program for the Aug. 5, 1967, clinic which will be the third in number.

Willard W. Fullerton, M.D., *Representative to the Illinois Joint Committee on School Health and chairman of the Committee.*



Economics & Insurance

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS EI-1

The Prepayment Plans and Organizations Committee met three times in the last six months of 1966.

One fee dispute was reviewed.

Guidelines for review procedures were developed and subsequently approved by the Board of Trustees in order to increase the efficiency and fairness of appeal hearings. They are as follows:

- A. A member who participates on a county or district level review committee may retain the right to serve as an active voting member of the Illinois State Medical Society Prepayment Plans and Organizations Committee if he so desires. He may retain

this right even though he may have previously sat in judgment on the same case.

- B. The committee will act only as an appellate body and not one of original jurisdiction. No additional evidence shall be taken at the hearing of an appeal. The committee retains the right to refuse any case if it so desires.
- C. The committee shall conduct appeals as formal review hearings.
- D. The committee shall notify all interested parties by registered mail with return receipt requested. The notice shall be sent at least 30 days in advance of the hearing. This notice shall state the time, place and date of the hearing and inform the recipient that he is entitled to appear before the committee.

E. The committee shall entertain an appeal only after a notice of such an appeal has been filed with the original county medical society by one of the interested parties. The county or district committee must notify the state society of the intent of appeal.

F. The decision of the committee shall be final. All parties shall be notified in writing of this decision.

The board approved the committee's recommendation that the Illinois State Medical Society have no policy on physician compensation for serving on a utilization review committee for an extended care facility. It also accepted the recommendation that county medical societies set their own policy to reflect particular conditions in each area and added the provision that physician compensation for this purpose would not be unethical.

The committee is currently engaged in conversation with the Illinois Hospital Association, the Illinois Society of Medical Record Librarians and the Health Insurance Council on the House of Delegates 1966 Resolution #18 regarding insurance carrier's access to hospital records.

The committee hopes to be able to develop basic guidelines for fee dispute procedures for local and district committees in the near future. These will be correlated with the guidelines already approved for the internal operation of the committee itself.

No estimate can be made at the present time regarding the volume of work which may develop under fee disputes and utilization review with private insurance carriers and Medicare carriers in the next year. Approximately twice as many meetings are anticipated in this fiscal year as in the last one.

Philip C. Lynch, *Chairman*

Maurice M. Hoeltgen H. Kenneth Scatliff

Michael R. Saxon E. Lee Strohl

Ted LeBoy, *Consultant*

CONSULTANT:

WALTER LIVINGSTON

COMMITTEE ON RELATIVE VALUE EI-2

Because of this Committee's experience with standard nomenclature and defining medical and surgical procedures, the American Medical Association has requested its assistance in preparing the second edition of the "Current Procedural Terminology". Dr. Burgess L. Gordon, editor of the CPT, plans to expand the medical section in the second edition scheduled for August release. The CPT, a standardized system of procedural terminology, was developed to facilitate the use of standard terms and descriptions for reporting therapeutic and diagnostic procedures.

Though the committee has not met at the time of this writing, its Relative Value Study—adopted

by the House of Delegates in May, 1963—continued to be in such demand that a reprinting was necessary. The publication, free to members of the state medical society, is available upon request.

Requests from non-physicians are considered on an individual basis and, if approved, a charge of \$1 is made. To date, 647 copies of the study have been sold to non-members, with the money deposited in the society's general fund.

This report is for information only and no action is required by the reference committee.

C. Elliott Bell, *Chairman*

John F. Eggers

Gershom K. Greening

Casper M. Epstein

Joseph G. Gustafson

R. Gregory Green

Max S. Sadove

Grover L. Seitzinger

MEDICAL ECONOMICS COMMITTEE EI-3

Two principal areas of concern occupied the committee's attention during the past year: 1) Reviewing the society sponsored Major Medical Group Disability and Retirement-Investment Programs; and 2) Exploring possible sponsorship of a high limit Accidental Death and Dismemberment program.

Group Disability Plan. The committee is pleased to report that the 1966 open enrollment period for admission into the ISMS Group Disability Insurance Program attracted some 550 new applications. Taking into account lapsed policies, deceased members and those who terminated their coverage for other reasons, the program experienced a net increase of 383 new members, increasing participation in the program to 2,114 members. According to Parker, Aleshire & Company—administrators—this represents a very successful increase in participation and premium volume.

Major Medical Program. The Major Medical Program presents a somewhat different picture in that only 62 new applications were processed during 1966 and a substantial number of lapses were incurred during the year. While we greatly increased the participation under this group plan in 1965, quite a few of the new insureds lapsed their coverage on the following renewal date in 1966. The total number of participants—as of Feb. 10, 1967—was 1,654 or a net loss of 85 during the past year.

Retirement-Investment Plan

Retirement-Investment Plan. During the open enrollment of the society's basic Retirement-Investment Program—from September through December 1966—73 new participants entered the program, bringing the total participation in the program to 187. The total investment in this program as of Jan. 5, 1967, is \$459,819. The committee approved another open enrollment period for the Retirement-Investment Program for the

fall of 1967.

Meanwhile, the society's tax-qualified retirement (Keough) program investment reached \$269,420, which brought total investments in both programs to about \$729,240. At the member's choice, monies are being invested in a group annuity through the Continental Assurance Company and/or the Stein Roe Farnham Inc. Mutual Stock Fund.

The committee feels it would be to the membership's advantage to offer it the opportunity to enroll in a \$1,000,000 Professional and Comprehensive Personal Catastrophe Liability policy. In view of the substantial rise in the amount of malpractice awards, the need for adequate limits of liability becomes increasingly important. The catastrophe liability policy the committee is considering would protect ISMS members with \$1,000,000 excess insurance over their basic professional liability, automobile liability and comprehensive personal liability policies.

Explore New Programs

While the committee has received the Board of Trustees approval to explore such program, it has not had time to study any of the proposed programs and formulate a recommendation. However, should a recommendation be formulated and submitted to the board at the time of the annual meeting, the committee will submit a supplementary report to the House of Delegates.

In addition to the Accidental Death and Dismemberment Program, the committee is also exploring other programs beneficial to ISMS members. One such project is the distribution of a Health Insurance booklet describing health insurance plans available to those over age 65.

Distribution of the booklet—published by the Health Insurance Institute—was prompted by the concern over the decrease of health insurance policies available to the aged with the advent of Medicare. The booklet, promoted in the *Pulse* newsletter and the *Illinois Medical Journal*, is a valuable aid in counseling patients on available programs to supplement Medicare benefits.

F. Paul LaFata, *Chairman*

Frederick Z. White, *Vice Chairman*

Bille Hennan

Philip C. Lynch

John J. Holland

Joseph B. Moles

A. Everett Joslyn

Robert E. Schettler

Lawrence J. Knox

R. Glenn Smith

CONSULTANTS:

Clifton L. Reeder

Walter Livingston

LIAISON COMMITTEE WITH HEALTH INSURANCE INDUSTRY and BLUE CROSS-BLUE SHIELD EI-4

On Sept. 22, 1966, the committee met with repre-

sentatives of Blue Shield to discuss mutual problems in conjunction with the administration of Medicare. While the law had been in effect less than three months, the following problem areas already were evident:

1. Payment of claims were being delayed because Blue Shield had to query Baltimore on the recipients' eligibility and the amount of deductible owing.
2. Confusion on the part of the beneficiaries was resulting in all kinds of bills—including non-receipted bills—being submitted by patients whose physicians were using the direct billing method.
3. Determination of whether a particular service should be charged to Part A or Part B of Medicare was also a serious problem. The confusion occurs mainly in out-patient diagnostic or therapeutic services and the services of hospital-based specialists. It was the opinion of Blue Shield that amending legislation is needed in these areas to simplify matters.

The use of special forms for initial certification and re-certification for hospital service was also discussed. It was noted that the Illinois Blue Cross plan is not demanding that special forms be used and the proper notations on the regular hospital records would suffice.

At its Jan. 15, 1967, meeting the Board of Trustees eliminated the Liaison Committee with the Health Insurance Industry and Blue Cross-Blue Shield and assigned its duties to the Prepayment Plans and Organizations Committee. The reasons for this action was to eliminate duplication of efforts by the committees.

Norris L. Brookens, *Chairman*

Robert G. England

Joseph C. Sodaro

Robert E. Fitzgerald

Paul Van Pernis

Dean G. Petersen

Theodore Wachowski

COMMITTEE ON HOSPITAL RELATIONS EI-5

The primary function of this committee is to work with the Illinois Hospital Association in sponsoring an annual Joint Conference of the ISMS and the IHS. Since the IHA requested eliminating the Joint Conference in 1967—and the committee did not meet during the year—the committee has nothing to report.

J. W. Buser, *Chairman*

John A. Bowman

Donald A. Meier

John M. Dorsey

Gerald S. Modjeska

Harlan English

Kenneth John Smith

CONSULTANT:

Noel G. Shaw

COMMITTEE ON USUAL AND CUSTOMARY FEES EI-6

The committee was appointed by the Board of Trustees in 1965 to define the concepts of usual, customary and reasonable fees, and to develop guidelines for the implementation of these concepts at the county, district and state level.

It was also charged with the responsibility of advancing the ISMS position on physician reimbursement from health insurance carriers, government intermediaries and government agencies who pay for medical services.

The committee met its obligation by:

1. Developing a set of "Guidelines for the Committee on Usual and Customary Fees and Governmental Agencies;"
2. Advising ISMS not to extend its contract with the Office for Military Dependents Medical Care;
3. Conducting a successful membership fee survey to learn the usual and customary fees charged by Illinois physicians;
4. Formulating an interim agreement with the Illinois Department of Public Aid on increased physicians' fees.

Adoption of Guidelines

Last summer, the committee drafted a set of "Guidelines for the Committee on Usual and Customary Fees and Governmental Agencies." The guidelines—approved by the Board of Trustees and mailed to the members—serve as a basis for all committee negotiations with governmental and private agencies.

Basically, they stipulate that ISMS shall refuse to enter into agreement with any program having a fee schedule or fixed fee limitation. All agreements between the society and third parties shall be on the basis of usual and customary fees, with fee adjudication review channeled through ISMS. The state society shall then forward all cases to the appropriate county society for action.

Dependents Medical Care Program

Last fall, the committee showed its determination in demanding usual and customary fees payment for physician services by recommending that ISMS refuse to renew its contract with the Dependents Medical Care Program which expired Oct. 31, 1966. The board concurred.

The government program—which provides medical services to military dependents and others—had functioned under a schedule of allowances (substandard fee schedule) ever since its inception in 1956. Despite ISMS' refusal to renew the contract, ISMS members are free to participate in the program, on an individual basis, if they wish.

Membership Fee Survey

In an effort to obtain usual and customary fee payment for physician services to public aid recipients, the committee held several meetings with Harold O. Swank, Public Aid Director.

While Mr. Swank indicated a willingness to reimburse some physicians on the basis of their usual and customary fees, he could not enter into an agreement until he had an accurate estimate of the cost of such program.

To assist Mr. Swank in projecting this cost accurately, the committee conducted a membership fee survey to determine the range of fees charged for various medical procedures. The results were outstanding, as more than 60 percent of our members responded to the four-page questionnaire.

As a result of this cooperation, ISMS was able to show that payment of usual, customary and reasonable fees would not result in astronomical costs to the Public Aid Department.

Increased Public Aid Payments

As a result of the information provided by the fee survey, the committee was able to reach an interim agreement with the Department of Public Aid whereby most physicians treating public aid patients would be paid their usual, customary and reasonable fee for the first six months of 1967.

The agreement, subject to approval by the ISMS House of Delegates and the Department of Public Aid, will more than double the yearly public aid payments to physicians—from a current \$7.5 million to \$15.5 million a year.

Under the new plan, physicians may bill for their usual and customary fees on all medical procedures. It is expected that most such billings will be paid in full; some few billings, however, will be adjusted to conform to the department's and ISMS' concept of reasonableness.

When a physician wishes to object to such adjustments, provision has been made in the planning for review by the county committee on Prepayment Plans and Organizations with the right of appeal to district and state committees. The department has the privilege of the same appeal. These committees also will review cases of alleged overutilization.

A basic part of the plan provides for adjustment of the department's concept of reasonableness as cost of living factors change. In turn, the department will consider unreasonable any escalation of fees above current levels unless this escalation follows agreement between the House of Delegates and the department.

The Department of Public Aid requested cooperation in the following areas in implementing the plan:

- A. To facilitate identification and evaluation of billings by machine, each procedure must be coded according to the AMA's

Current Procedural Terminology.

- B. The doctor must include on each bill his AMA Medical Education Number, the name of the county in which he has his business office, and the Public Aid identification number of the patient.
- C. While quantity limitations will not be a factor in the review of bills for payment, the department will post-audit bills to determine if quantity standards are in fact necessary in an on-going program.
- D. Federal regulations require physicians to accept an assignment if they expect to receive payment of the deductible and co-insurance amounts for Public Aid patients who have coverage under Part B of Medicare.
- E. Copies of the Form 1490 billing form for Medicare patients should be sent to the Department of Public Aid in Springfield, and should include the appropriate procedure code number for the service rendered, as well as the Public Aid identification number.

ISMS members were informed of the new program through a membership mailing, as well as stories in the *Pulse* newsletter and the *Illinois Medical Journal*.

In view of the apparent success of the new reimbursement program allowing most physicians their usual, customary and reasonable fee, the committee strongly urges the House of Delegates to approve its continuation and extension to other programs.

Philip G. Thomsen, *Chairman*

George F. Lull

Joseph Shackelford

G. R. Marshall

V. P. Siegel

Joseph R. O'Donnell

Francis W. Young

CONSULTANT:

WALTER LIVINGSTON

MEDICAL ADVISORY COMMITTEE TO THE ILLINOIS DEPARTMENT OF PUBLIC AID EI-7

The Medical Advisory Committee to the Illinois Department of Public Aid meets regularly on the Saturday preceding the Board of Trustees meetings. The committee serves in an advisory capacity to the department and provides sub-committees on ophthalmology, anesthesiology, radiology, and cardiovascular disease. Sub-committee members are contacted directly for their recommendations on specific cases.

The committee's responsibilities include medical care policies, procedures and problems arising in the public aid program. Two previous responsibilities—cost and quantity limitations—have been removed from this committee's consideration. Problems concerning fees are referred to the Com-

mittee on Usual and Customary Fees. Quantity limitations have been removed on a trial basis. The department will conduct a post-audit of bills to determine if these limitations are necessary.

Facilitate Payments

To facilitate payment of physicians' bills under the department's new reimbursement program the department announced three innovations for 1967: (1) Use of the American Medical Association's "Current Procedural Terminology" to expedite processing; (2) Pre-coding the 60 most frequent claims as reported by the National Association of Blue Shield Plans on the back of the new billing form; and (3) Introduction of machine processing of physicians' statements. The department has asked for physicians' cooperation in coding their procedures to facilitate the identification and evaluation of billings to speed payment.

The new form, MS-132 (Revised), has two parts—Part I, Report of Routine Services, is pre-coded so that you only indicate the date and charge for the service. If you use Part II, Report of Other Services, you should indicate the code numbers, the procedures and services furnished, diagnoses and your charge.

Committee Recommendations

The committee has recommended that whenever possible, recipients who have had major amputations be referred to an amputee clinic for evaluation before purchase of a prosthesis or extensive bracing by the department. The referral will be made only with the knowledge and consent of the physician recommending the prosthesis. The amputee clinics will provide a comprehensive evaluation of the amputee patient's physical, emotional, social, and economic status, and—when indicated—prescribe an appropriate appliance.

This service will assure that artificial limbs and extensive bracing will be provided recipients who can benefit from their use, that optimum use of the appliance will be attained, and available funds will be used more efficiently.

The committee also approved a study program to provide treatment in private hospitals for public aid recipients who are drug addicts. The committee recommended that addicts be carefully screened to determine their rehabilitation potential and treated at hospitals staffed and equipped to provide appropriate care and supervision. The committee supports this study program which treats the drug addict as a patient rather than a criminal.

Approve Payment Policy

The committee approved the department's present policy on payment for oxygen service in nursing homes and approved extending this policy to include the rental or purchase of oxygen equip-

ment for use in the recipient's home. Payment is limited to a maximum of three hours a day. Exceptional circumstances for oxygen services exceeding three hours may be authorized by the county department upon the written order of the attending physician with a review and approval by the county medical advisory committee. The committee hopes to assure close medical supervision of extensive oxygen administration.

The committee was requested to recommend conditions under which payment for hemodialysis should be authorized. Prior to requesting the committee's advice, the department had received requests to pay for dialysis in hospitals and for the equipment and supplies for home dialysis. Because of the excessive cost of this treatment—whether in the hospital or home—none of these requests had been approved by the department.

Fred A. Tworoger, *Chairman*

Rex O. McMorris, *Vice Chairman*

Charles E. Baldree, Jr. L. C. Nesbitt

Robert F. Bettasso Frank B. Norbury

James R. Cooper Alphonse L. Robinson

Heniz Otto E. Hoffmann William Scanlon

Chauncey C. Maher, Jr. Frank P. Skaggs

George T. Mitchell John H. Steinkamp

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CONSULTANTS:

Edwin S. Hamilton Burtis E. Montgomery

George F. Lull Robert C. Muehrcke

Walter R. Livingston

COMMITTEE ON DRUGS AND THERAPEUTICS EI-8

Since this committee's responsibilities have been broadened to include the evaluation of new drugs and drug matters affecting the policy of the state medical society, its name has been changed to the Committee on Drugs and Therapeutics. The committee continues to refine the list of drugs contained in the Drug Manual prepared at the request of the Illinois Department of Public Aid.

In order that the manual will reflect the prescribing habits of Illinois physicians, the committee has spent many hours reviewing physicians' requests for drugs not listed in the manual. A complete and accurate record of drug requests and committee actions are kept in the society's office. In developing its recommendations for revisions in the Drug Manual, the committee is guided by the frequency with which an unlisted drug is requested.

During 1966, the committee reviewed 726 special written requests for drugs not listed in the manual and more than 99 percent were approved. However, a number of requests had to be returned for additional information such as the patient's name or the medical facts in the case and these are not included in the count.

While the Drug Manual is thought to list the drugs required in the everyday practice of medicine, the committee does not consider it final. Continued experience and constructive criticism by the membership have made it necessary to continually evaluate the listed drugs. The committee's recommendations are reported to the Board of Trustees for approval before being submitted to the Illinois Department of Public Aid for its approval, publication, and distribution to participating physicians.

During the past year the committee recommended to the department that 41 new items be included and that specific listings be given additional forms of 11 drugs already in the manual.

The committee utilized the public aid IBM drug usage tabulations as its guide to determine if deletions should be recommended. Thirteen drug forms were not prescribed during the first month of each quarter of 1966, and the committee has recommended their deletion. The drugs are still included in the manual—only the specific form was dropped.

The department accepted these recommendations and is now reprinting the loose leaf Drug Manual to include them. The new edition should be released prior to the annual meeting.

The committee is preparing to analyze further the IBM data made available by the department and hopes to publish this as a study. The committee feels the material may be developed into a useful teaching device.

The Committee on Drugs and Therapeutics expects legislation to be introduced in the 90th Congress to restrict the use of trade-mark or brand name prescription drugs for patients covered under Titles XVIII and XIX of the Social Security Act. It will probably require that all medicine be prescribed and furnished on a non-proprietary or generic basis. This would not give consideration to the wide variation in quality or standardization that exists among generic drugs. The committee feels that a program of this nature would restrict the physician in providing his patients with high quality medical care.

At the committee's recommendation, the Board of Trustees stated its opposition to such legislation and has directed ISMS to work with other groups in opposing legislation of this type. The board further approved the recommendation that the society prepare written testimony to be submitted when hearings are held. The committee is willing to prepare this testimony or work with other committees in setting forth the ISMS position.

The committee would like to remind the House that while the Drug Manual does contain generic and non-proprietary listings, the pricing structure of the department is based on quality products

so that cost will not be a primary factor. The pharmacist must indicate on the prescription form the name of the manufacturer whose product is supplied for non-proprietary or generic prescriptions.

The committee appreciates the cooperation it has received from the members as a whole. It welcomes their suggestions and comments and will be guided by their sound therapeutic recommendations when making recommendations to the Illinois Department of Public Aid for future revisions of the Drug Manual.

This is a report of information and no action is required by the reference committee.

Robert C. Muehrcke, *Chairman*

James A. Weatherly, *Vice Chairman*

Joseph D. Cece Charles R. Frazer

CONSULTANTS:

Theodore L. Sherrod Louis Gdalan

Walter Livingston

ILLINOIS DEPARTMENT OF PUBLIC AID EI-9

Two years ago the public aid budget was set at \$661 million and it was estimated that \$363 million of this would be state funds while \$298 million would be federal. It appears now—with the conclusion of the 74th biennium next June 30—net state expenditures will be \$29 million less than anticipated while the federal share will be about \$38 million higher and the total probably will be around \$669 million.

At the beginning of this biennium we estimated that \$181 million would be required for the medical assistance program; at this point it looks like medical expenditures by June 30 will be \$191 million, ten million dollars more than originally estimated. Moreover, it appears that for the 75th biennium, which begins in July, the department will need \$354 million for the medical program. The substantial increase includes funds from which will be paid to other departments of state government in order to qualify for maximum federal matching. However, it also includes the amounts required as a result of rising costs of medical payments for a variety of goods and services.

The department is fully aware of the importance of tentative agreements recently reached with the Illinois State Medical Society whereby physicians may bill the department for their usual and customary fees on all medical procedures. During this second year's experience in Illinois, under Title XIX, we look forward to a continuing improvement in the medical program. It is expected that fee payments will more than double the yearly public aid payments to physicians and that most bills will be paid in full. Some billings, however, will be adjusted to conform to the department's and ISMS's concept of reasonableness and may be subject to review by the appropriate local committee.

Realizing that mutual co-operation is a two-way street, the Department of Public Aid will make every effort to process payments promptly directly from Springfield. Moreover, we shall make every effort to avoid unnecessarily complicated administrative procedures consistent with good medical care administration and full compliance with federal regulations. In order to achieve these objectives it will be necessary for the physician to complete Form MS-132, "*Physician's Statement of Services Rendered*," with special attention to coding each procedure for which he expects payment in accordance with "*Current Procedural Terminology*" of the American Medical Association and to insert his *Medical Education Number* in the proper space.

Regarding preventive services, the department expects to pay physicians for physical examinations of school children as required by Illinois law in families of recipients of public aid when such services are not otherwise available.

We are hopeful that it will be possible for the department to bring its medical problems to a single committee of ISMS at the state and county levels to minimize confusion and misunderstanding. If additional committees are to be concerned, it would seem appropriate for this committee to serve as the vehicle for such references. Our experience leads us to believe that a number of specialized committees cannot do justice to the total problem area involving fees, utilization, medical practice and many other things.

Harold O. Swank, *Director*



Legislation and Public Affairs

COMMITTEE ON QUACKERY LP-1

Many of the members of the Quackery Committee attended the Third National Congress on Medical Quackery held in Chicago on Oct. 7 and 8, 1966.

This American Medical Association and National Health Council joint sponsorship focused much attention on present-day quackery dealing with drugs, devices, nutritional nonsense, food fanatics, obesity, krebiozen, mental health, literature and advertising, and the cost of quackery, as well as the major quackery problems dealing with chiropractors.

The Quackery Committee's main interest in the state of Illinois was to keep informed of the findings of the Division of Investigation of the American Medical Association which had reported on a number of problems in Illinois. Several cases were reported to the Department of Registration and Education for further follow-up, as well as the Attorney-General's office of the state of Illinois.

Every doctor in the state of Illinois is urged to

become familiar with every evidence of quackery in the state of Illinois and send such reports as may be available to the state medical society office for action of the Quackery Committee.

Much can be done in the state of Illinois not only in newspaper advertising but also by informing television and radio broadcasters of unscientific announcements which may be sponsored by quacks.

The Illinois chiropractor situation has been reviewed thoroughly with the Medical Examining Board of the Department of Registration and Education and the committee is most eager to work with this board, as well as the Legislative Committee of the Illinois State Medical Society in controlling quackery legally as much as possible.

Edward A. Piszczek, *Chairman*

Robert R. Bates
Casper Epsteen
Herbert V. Fine
John S. Kapernick
Donald A. Meier
Mladen Mijanovich

Raymond B. Murphy
Charles W. Pfister
William B. Rich
Simon Y. Saltman
T. R. Van Dellen
Wilson H. West

Walter Wood

COMMITTEE ON LEGISLATION LP-2

As of the date of writing this report, your committee has met four times since the last annual meeting. At least two additional meetings are planned. Following each meeting your committee has reported the important legislative matters to the Board of Trustees for guidance and interim policy decisions. In addition to the formal committee activity, we have utilized other physicians on a series of sub-committees to study specific problem areas. Each of these sub-committees has been chaired by a member of the Legislative Committee.

FEDERAL LEGISLATION

Following the customary pattern, your committee worked closely during the year with the American Medical Association on federal legislation, lending support for medicine's position through contacts with the Illinois Congressional Delegation. As predicted, the 89th Congress, adjourning in October, 1966, was the most prolific Congress in history with respect to medical legislation. In our report last year we listed some 18 health measures which were enacted during the first session. Following is a supplemental listing of health measures enacted during the second session:

HEALTH LEGISLATION ENACTED 89th CONGRESS, SECOND SESSION:

<i>Public Law</i>	<i>Description</i>	<i>Bill No.</i>
89-357	World Health Assembly. Authorizes an appropriation to hold the 22nd World Health Assembly in Boston, Mass., in 1969.	H. J. Res. 403
89-358	GI bill for veterans serving after Jan. 1, 1955. Includes presumption of service connection for certain diseases and disabilities, and authorizes hospitalization for non-service-connected disabilities.	S. 9
89-544	Regulation of Sale and Use of Animals Used in Research. Authorizes the Secretary of Agriculture to regulate the transportation, sale, and handling of dogs, cats and other animals intended to be used for research or experimentation.	H. R. 13881
89-563	Traffic Safety Act of 1966. Provides for a coordinated national safety program and establishment of safety standards for motor vehicles in interstate commerce.	S. 3005
89-564	Highway Safety Act of 1966. Provides for a coordinated national highway safety program through financial assistance to the states.	S. 3052
89-601	Fair Labor Standards Amendments of 1966 (Minimum Wage Law). Amends the Fair Labor Standards Act of 1938 to extend its protection to hospital employees and raises the minimum wage.	H. R. 13712
89-609	Male Nurses in Armed Forces. Authorizes the commissioning of male nurses in the regular armed forces.	H. R. 420
89-612	Extension of Benefits for Philippine Veterans. Provides for extension and expansion of the program of grants-in-aid to the Republic of the Philippines for the hospitalization of certain veterans.	H. R. 16330
89-614	Military Medical Benefits Act of 1966. Authorizes an improved health benefits program for retired members and members of the uniformed services and dependents.	H. R. 14088
89-675	Clean Air Act Amendments of 1966. Authorizes grants to air pollution control agencies for maintenance of air pollution control programs in addition to present authority for grants to develop, establish, or improve such programs; makes the use of appropriations under the act more flexible and extends duration of the programs authorized by the act.	S. 3112
89-698	International Education Act of 1966. Authorizes \$50,000 to study "international brain drain".	H. R. 14643
89-705	Earmarks a minimum of \$100,000 for research by the VA into spinal cord injuries and diseases.	H. R. 203
89-709	Veterinary Medical Educational Facilities Construction Act. Authorizes a three-year program of grants for construction of veterinary medical education facilities.	H. R. 3348
89-713	"Reasonable costs" for extended care facilities under Medicare.	H. R. 6958
89-749	Comprehensive Health Planning and Public Health Service Amendments.	S. 3008
89-751	Allied Health Professions Personnel Training Act.	H. R. 13196

<i>Public Law</i>	<i>Description</i>	<i>Bill No.</i>
89-753	Clean Waters Restoration Act of 1966. Amends the Federal Water Pollution Control Act and establishes a program of river basin pollution control and abatement.	S. 2947
89-754	Demonstration Cities Act. Provides for mortgage insurance for non-profit group practice facilities.	S. 3708
89-755	Prevents use of unfair or deceptive methods of packaging or labeling of certain consumer commodities.	S. 985
89-756	Child Protection Act. Bans hazardous toys and articles intended for children.	S. 3298
89-785	Veterans Hospitalization and Medical Services Modernization Amendments. Clarifies VA educational activities; makes numerous administrative changes in the Department of Medicine and Surgery, and authorizes the exchanging of medical facilities, equipment and information with local hospitals and medical schools.	H. R. 11631
89-793	Narcotic Addict Rehabilitation Act. Authorizes civil commitment of addicts in lieu of criminal prosecution.	H. R. 9167
89-794	Economic Opportunity Amendments of 1966. Clarifies OEO authority with respect to family planning and authorizes the establishment of neighborhood health clinics.	H. R. 15111
89-809	Foreign Investors Tax Act. Includes the Keogh Act Amendments.	H. R. 13103

Health Planning & Services

Among the foregoing measures, your committee gave special assistance to the AMA in transmitting medicine's view to Congress on the Comprehensive Health Planning and Public Health Services Amendments of 1966 (PL-89-749). This law establishes in each state, and by regions within the state, planning bodies to determine the health needs of the people. It also substitutes unrestricted grants for the former categorical grants for public health services. Your committee is in agreement with the objectives of this legislation but is concerned with the manner in which it will be implemented, particularly the type of services to be rendered. In Illinois the Department of Public Health has been designated by the Governor as the implementing agency. A special planning division has been established within the department.

Your committee has been designated by the ISMS Board of Trustees to follow these developments and to maintain liaison with the Department of Public Health relative to implementation of this law.

Heart, Cancer, Stroke

As reported to you last year, your committee has been given a similar follow-up assignment with the Department of Public Health on the implementation of Regional Programs for Heart Disease, Cancer and Stroke, enacted in 1965, (PL-89-239).

The original separate Chicago and Downstate Advisory Committees for this program have been combined into a statewide committee under the chairmanship of Dr. Oglesby Paul. Representation from the five medical schools has been combined in anticipation of a single joint program operated by all of the medical schools. A request for more geographi-

cal representation from practicing physicians has been met by designation of the ISMS Board of Trustees as a medical advisory panel to the committee. A similar committee and program, established for the St. Louis area, will extend into Southern Illinois. ISMS members from that area are serving on the St. Louis Advisory Committee.

The major thrust of this program is expected to be oriented toward post-graduate education for the profession. No funds have yet been provided for the program although a request for funding is pending. Dr. Wright Adams has been appointed as program director.

Hart Bill

Senator Hart (D-Mich.), chairman, Sub-committee on Monopoly, Senate Judiciary Committee, failed to obtain action on his medical restraint of trade bill during the 89th Congress. For several years, Senator Hart has conducted investigations of pharmacy ownership and drug-eyeglass dispensing by physicians. The Senator's bill in the 89th Congress would have outlawed any dispensing at a profit. A new bill, introduced in the 90th Congress, would make it illegal for any doctor to own a pharmacy or to dispense drugs or eyeglasses (S-260). Exceptions would allow dispensing under emergency conditions or in unit doses and pharmacy ownership in areas having no other facility.

Your committee has repeatedly joined AMA in opposing this type of legislation. It is considered discriminatory and likely unconstitutional. Also, it prohibits practices which are not barred by medical ethics. The Executive Director of the Illinois Pharmaceutical Association has launched a "one-man" campaign of vilification against physicians who own pharmacies, based upon alleged abuses in Olney

which could not be substantiated by an ethics committee investigation. Upon advice from AMA, an invitation to testify at the January hearing on S-260 was declined. These hearings, as well as those in the past, have been designed to attract newspaper headlines rather than new facts on the issue.

MEDICARE IMPLEMENTATION

Facilities and Utilization

Medicare went into effect July 1, 1966, with little or no immediate effect upon the hospital census. By the beginning of 1967 the situation had changed and bed shortages were reported from numerous quarters due to over-crowding from Medicare patients. Surprisingly few complaints were received about the activities, or lack of activity of Utilization Review Committees. The extended care benefit went into effect in January with a very limited number of approved facilities available. Likewise, only a limited number of home health services plans are available. The potential for a breakdown in facilities due to over-crowding from Medicare obviously exists but the situation has not as yet shown critical proportions.

Certification

During the year a problem arose in a number of areas over certification requirements for initial hospital admission. Much of this stemmed from over-zealous hospital administrators demanding the use of non-official printed forms, distributed by the American Hospital Association. Working closely with Blue-Cross, we were able to make it clear that no forms are required and that any identifiable form of certification, acceptable to the hospital and its medical staff, will suffice. This subject was fully explored at the AMA Clinical Session in December and agreement reached that any form of certification for hospital admission was unnecessary and objectionable. However, it was also agreed that no permanent solution to the problem was possible without a change in the law. In line with this, the following recommendations of your committee were presented and approved at the January, 1967, meeting of the Board of Trustees:

1. That ISMS should reaffirm opposition to any special form of certification other than the usual hospital records containing adequate progress notes. (October, 1965, committee recommendation.)
2. That ISMS will support the AMA in seeking amendments to PL-89-97 to this effect.
3. Pending a legislative solution to the problem, the manner of meeting existing certification requirements is one of local option between the hospital board and medical staff.
4. That once a plan of action has been agreed to by majority vote of the medical staff, the individual physician should then comply.

The Administration has since conceded this point and is now advocating a change in the law to remove the certification requirement for initial hospital admission. (See HR-5710 below.)

Hospital Based Specialists

Problems with respect to independent billing for hospital based specialists, encountered just prior to the inauguration of Medicare, seemed to subside as the program got under way. Some additional specialists have established themselves completely independent of the hospital, but the majority remain in about the same status as before Medicare, with the hospital doing the billing and collecting of professional fees. Progress has been made in the struggle to overcome hospital domination by Medicare's requirement for itemization of the professional component on all billings, also the requirement for billing the professional component to Part B. However, a strong move is now under way to return the in-patient diagnostic X-ray and laboratory services, including the professional component, to Part A (see HR-5710).

Social Security Amendments of 1967, HR-5710:

The Administration's proposal for changes in the Social Security Law was introduced in the House Ways and Means Committee as HR-5710 by Chairman Wilbur Mills on Feb. 20.

In addition to many changes in the cash benefits and welfare sections, the bill provides for changes in Medicare and the Title XIX Medical Assistance Programs. Some important highlights of these latter changes are:

1. Medicare coverage provided for the disabled below 65 years of age.
2. Inclusion of non-routine podiatry services under Part B (excludes removal of corns or calluses and nail clipping).
3. Removal of physician certification for initial hospital admission (retains re-certifications for extended stay).
4. Creates new "Part C" which has the effect of placing in-patient diagnostic X-ray and laboratory services, including the professional fees, under Part A and removes the deductible and co-pay features. Out-patient benefits would be removed from Part A and placed under Part B, with the \$50 deductible and 20 percent co-pay features applying.
5. Under Title XIX—places income limits on eligibility, provides for free choice of vendor, provides the same amount for administrative costs regardless of which state agency administers the program, and provides for a national advisory council.

Title XIX—Transfer of Administration

In accordance with Resolution 66M-48, adopted by the 1966 House of Delegates, a letter was dispatched to the Governor expressing the desire of

ISMS to have the administration of Title XIX transferred from Public Aid to Public Health. The Governor's reply indicated an open-minded stand on the issue and a willingness to explore the proposal further. Subsequent to this, active negotiations got under way between ISMS and the Director of the Public Aid Department, relative to a new method of payment based on usual and customary fees. The new payment program was adopted in January. In view of the many problems which may reasonably be anticipated in successfully launching the new program, no further specific action on the possible transfer of administration has been taken. The matter is under further study.

Direct Billing Under Title XIX

Public Aid recipients, who also hold Part B Medicare coverage are expected to assign the Medicare benefit to the physician for payment from the carrier rather than deal on a direct billing basis between physician and patient. If this is done, Public Aid has then agreed to make payment toward the \$50 deductible, the 20 percent co-payment and other items not covered by Medicare. The problems encountered with this are twofold; many physicians have received little or nothing from Public Aid for the balances due, and some physicians object to the restriction on direct billing which is provided for under the Medicare law. Hopefully, the first problem will be largely overcome under the new payment method based on usual and customary fees. Failure to receive these additional payments has been due to the use of the sub-standard fee schedule. This should no longer occur except in cases where the physician's fee exceeds the usual and customary amounts determined for the program.

The prerogative of the physician to direct bill patients with Medicare coverage is fully recognized. However, a change in the federal law is necessary before this feature can be made compatible with the existing Title XIX program. The AMA is seeking an amendment to the law to permit direct billing under the Title XIX program. Pending a legislative solution to this problem, the following course of action was adopted by the Board of Trustees in January:

1. That we lend all assistance to the AMA in their efforts to change the law.
2. To advise ISMS members that under present law and regulations, it may be difficult or impossible for the physician to be paid directly by recipients of Title XIX. Since we have agreed to abide by the law, while at the same time seeking corrective amendments to the law, the individual physician will be required to decide what he will do with respect to billing for services rendered to the patients.

STATE LEGISLATION

Following the last meeting of the House of Dele-

gates, your committee began a study of numerous issues in preparation for the 75th Illinois General Assembly. The services of other ISMS committees were utilized for this purpose as well as the services of special legislative sub-committees previously mentioned. By the time the General Assembly opened in January, we were prepared to move ahead with the introduction of several of our own bills or to support legislation developed by others in these fields. Below is a listing, by category, of the various bills and proposals being supported as of the date of preparation of this report, March 13. Additional bills will be listed in a supplemental report submitted at the time of the Annual Meeting.

BILLS AND PROPOSALS BEING SUPPORTED

Automobile Safety

1. *Medical Review Board*: Would establish procedures within the Department of Public Health for a board of physicians to consider physical and mental disabilities of drivers and make recommendations to the Secretary of State regarding driving privileges. This legislation will be introduced under the sponsorship of the Secretary of State.
2. *Alcohol Content (S-7)*: This bill would reduce the present blood alcohol content for presumed intoxication from 0.15 parts by weight to 0.10. S-7, introduced by the Senate leadership, has passed the Senate and is now under consideration in the House.
3. *Implied Consent (S-8)*: Under this bill, application for a driver's license would imply consent to testing for suspected drunken driving. Failure to accept testing would result in a 6-month license suspension. Blood and breath testing would be authorized. Immunity would be provided for those who draw blood for testing purposes. This bill, introduced by the Senate leaderships, has passed the Senate and is now awaiting House action.
4. *Driver Re-examination*: The principle of periodic re-examination for eye-sight, hearing and other general physical conditions, which affect safe driving, is being supported. Two bills, H-86 and S-166, introduced in this field, have been given favorable review by the ISMS Public Safety Committee. However, cost and feasibility of testing as well as Federal highway safety requirements will largely determine the type of legislation which will finally be enacted. No committee hearings have yet been held on these bills.

Other Safety Bills

1. *Flammable Fabrics (S-222)*: Would require proper safety standards for articles of clothing and other fabrics manufactured and sold in Illinois. The bill has undergone numerous changes to overcome the objections of manufacturers and

merchants. Hearings are under way in the Senate.

2. *Laser Beams*: A bill to require the registration of equipment using laser beams and providing for safety checks, has been drafted by the ISMS Environmental Health Committee. Sponsors are now being sought.

Narcotics and Dangerous Drugs

1. *LSD Control (H-4)*: Would classify LSD and similar hallucinogens as dangerous drugs, making them available only on prescription. A penalty provision for possession provoked debate in the House but the bill passed with only seven dissenting votes and is now in the Senate.
2. *Paregoric Exemption (H-200)*: Amends the present exemption from prescription of small quantities of opium and morphine products to make these available, over-the-counter, only when mixed with substances which will prevent the extraction of the narcotic. This bill has passed the House.
3. *Narcotic Rehabilitation*: As an outgrowth of legislation supported in the 74th General Assembly which established a Narcotics Advisory Council, a bill to create a rehabilitation program for addicts has now been developed by the council. This proposal enjoys the support of the ISMS Narcotics Committee and is consistent with the federal legislation recently enacted. The appropriation requested for the program is \$2,359,200. The bill will be introduced by the Narcotics Advisory Council.

Public Health

1. *Air Pollution (H-129)*: Would create an official commission to survey and study air pollution problems and report back to the next General Assembly. Appropriates \$25,000. This bill has been favorably reported from committee in the House.
2. *Fluoridation (S-516)*: Provides that the Department of Public Health shall promulgate rules for the fluoridation of public water supplies; provides that the fluoride shall be not less than 0.9 mgs per liter nor more than 1.2 mgs per liter.
3. *Renal Disease (H-611)*: Appropriates \$1 million to the Department of Public Health for a program of care of persons suffering from chronic renal diseases. The bill provides for an advisory committee with medical representation.
4. *Immunization (H-431)*: Upon the recommendation of the ISMS Child Health Committee, proposed legislation to require all school children to be immunized is being supported. Immunization against diphtheria, pertussis, tetanus, poliomyelitis, small pox and measles would be required before the child may enter school. H-431 submitted by Representative Wolbank, would require vaccination against measles only.

It is anticipated that this bill will be amended to include the other recommended immunizations or that other legislation will be submitted.

5. *Restaurant Licensing*: A proposed bill, developed by the Department of Public Health would license food-service establishments and wholesale food-processing establishments, not otherwise licensed under local laws. Uniform standards of sanitation and operation would be required. A license would be required before the facility could be opened. The bill will be introduced as an Administration measure.

Medical Practice Act Amendments

1. *Improved Enforcement*: Several proposed bills to improve enforcement under the Medical Practice Act and to curb undesirable practices, have been developed jointly by ISMS and the Department of Registration and Education. These include: 1) prohibition against unethical advertising by persons licensed under the Medical Practice Act, including chiropractors; 2) technical changes in the method of conducting hearings for the revocation of a license, including a provision that the department shall investigate all verified, written complaints of violations; 3) consolidation of the penalty provisions found in various sections of the act, and making the second violation a felony rather than a misdemeanor. These will be departmental bills. This joint effort with the department will be supplemented by an additional ISMS bill permitting individuals, other than the Director of the Department of Registration and Education to apply for a court injunction to restrain persons from practicing in violation of the act.

One additional departmental bill, H-145, has been submitted and has passed the House. This bill provides for the suspension of a license under the Medical Practice Act if the holder is convicted of a felony in another state or in a federal court. The present act applies only to convictions in Illinois.

2. *Citizenship Requirement (S-475)*: Despite ISMS opposition, the 1965 General Assembly removed the requirement that an applicant for a medical license must file a declaration of intent to become a citizen and complete the citizenship within five years in order to renew the license. S-475, introduced at the request of ISMS, would restore this provision.
3. *Utilization Review Committee Immunity*: A bill to provide legal immunity for members of Hospital Utilization Committees has been drafted and approved. Sponsors are now being sought.
4. *Corporate Practice*: A bill to prohibit the practice of medicine by any corporation, other than a medical corporation, will be introduced under ISMS sponsorship. This bill is designed to eliminate practices followed by hospitals which employ physicians who render professional serv-

ices and for which the hospital bills and collects a professional fee. Such practices are in conflict with medical ethics. Precedent for this type of legislation is established by similar prohibitions in the Dental Practice Act and the statutes governing the legal profession. Sponsors for the bill are now being sought.

5. *Fees at Research and Educational Hospitals (H-25)*: This bill would permit the collection of professional fees at the University of Illinois Research and Educational Hospitals. These institutions are now prohibited from collecting professional fees under their enabling statute. Service is rendered by full-time faculty members. This bill will be acceptable when amended to provide that the physician-members of the medical staffs retain control of the billing, collecting and disbursement of these fees. The University has agreed to a Medical Service Plan which would provide for this control. The ISMS position is based upon items 6 and 7 of the below listed eight-point Policy Statement on Payment for Professional Medical Services, adopted by the AMA House of Delegates at the 1966 Clinical Session:

**POLICY STATEMENTS ON PAYMENT
FOR PROFESSIONAL MEDICAL
SERVICES
(as amended)
ADOPTED BY
AMA HOUSE OF DELEGATES 1966
CLINICAL SESSION**

1. It is proper for the physician to establish the fee which he charges to any patient for the professional service rendered, with recognition of the fact that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge.
2. It is proper for third party agencies to make payment of professional medical fees in behalf of patients, with recognition of the fact that the service of the physician has been to the patient and the liability for payment rests primarily with the patient or his family.
3. It is proper for a physician to work cooperatively with other physicians in a team approach to the provisions of medical service, with recognition of the fact that each cooperating physician is entitled to compensation according to the value of his services, and that charges attributable to each physician's service shall be made clearly known to the patient.
4. It is proper for a physician who provides personal supervision and direction for a physician-in-training to charge for the professional medical service rendered.
5. A physician should not enter into a contract

or agreement with a hospital whereby the hospital acts as the agent for a physician unless it is with the consent of the physician and of the medical staff. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the Principles of Medical Ethics and established policy of the American Medical Association.

6. Physicians, collectively in hospitals, may properly establish special medical staff funds, wholly under their own control, which they may support as they see fit, disburse as they may agree.
7. Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency.
8. The physician is the sole arbiter as to the ways in which he may dispose of his professional income, without duress, consistent with the laws of the land and the Principles of Medical Ethics of this Association.

The position taken on this bill by the Legislative Committee was ratified by the Board of Trustees at the March meeting. Statements 6 and 7 in the foregoing list were adopted as the ISMS position with respect to payment for medical services in hospitals which employ paid staff.

6. *Suspensions of License for Mental Commitment*: The Medical Practice Act currently provides for the automatic suspension of a license upon the entry of a court decree, establishing the insanity or known mental illness of any person holding a license under the act. A 1965 amendment to the Mental Health Code provides that neither initial hospitalization, upon court order, nor authorization of continued hospitalization, upon court order, nor admission under any other provision of the act, shall deprive a person of his license. The two acts are thus in conflict. Discussions are under way as to how this conflict may be resolved. Your committee is supporting the position that the medical license should be suspended while a practitioner is undergoing mental treatment.

Other Licensing

1. *Hypnotists*: A bill has been drafted by ISMS which would restrict the use of hypnotism to doctors of medicine, dentists and licensed psychologists. Sponsors are now being sought.
2. *Clinical Laboratories*: An amendment to the Illinois Clinical Laboratory Act has been developed by ISMS to provide that only fully licensed doctors and dentists (for dental laboratories) may direct clinical laboratories. An exception would be made for all existing licensed laboratories under the so-called "grand-father clause".

Miscellaneous

1. *Abortion Laws (H-372)*: Would establish a commission to study the need for changes in the abortion laws. The commission would report back to the next General Assembly in 1969. Your committee believes that opinion among the medical profession is divided on this issue. A conference to explore the medical aspects of updating the abortion laws was conducted on March 15. Support is being given to H-372 since it provides an opportunity for further study. Another bill on this subject, H-715, which would legalize abortions when the mother's life is endangered or health gravely impaired, the child is suspected of physical or mental defects, or the pregnancy is the result of forcible rape or aggravated incest, is not being supported.
2. *School Employee Physical Examinations (S-193)*: Present law requires that all new school employees be examined at the employee's expense. Free choice of physician is allowed. This bill provides that when the Board of Education requests and pays for an additional physical examination, the board may designate the physician to perform the examination. This is acceptable practice in industry. The bill is being supported.
3. *Board of Higher Education Study (S-177)*: This bill would provide an emergency appropriation of \$100,000 to the Board of Higher Education to complete a study of medical and health related education needs which is now under way. The bill has been amended to require that particular concern be given to the provisions of an adequate number of general practitioners in the field of medicine. This bill is being actively supported due to the need for additional practitioners to serve in the downstate area.
4. *Hospital Emergency Rooms*: Current laws provides that every hospital must maintain an emergency room. A proposal by the Illinois Hospital Association to amend the law to allow hospitals, in a multi-hospital area, to provide emergency coverage through one facility, is being supported. It is anticipated that such a bill will be introduced under the sponsorship of the Illinois Hospital Association.

OTHER LEGISLATION

Your committee is actively monitoring many other bills, most of which have a limited application to the practice of medicine or to public health. Several other bills are being studied to determine our position. The sponsors of highly undesirable bills frequently can be convinced to allow their bills to die in committee without ever being called for consideration. Several bills in this category are being closely watched. A supplemental report will be submitted at the time of the meeting of the House of Delegates.

Your committee wishes to thank the officers and members of the Board of Trustees for their advice and guidance, those who have served on the study sub-committees, and the many members of the county medical societies who have aided with the legislative program. We also wish to express appreciation to Mr. Frank Pfeifer and Mr. Jack Neal for their legal advice. Appreciation is also extended to our legislative staff.

Respectfully submitted:

V. P. Siegel, *Chairman*

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MEDICAL-LEGAL COMMITTEE LP-3

The Medical-Legal Committee is pleased to report that the Illinois Supreme Court in new rules, effective Jan. 1, 1967, has granted a major concession to physicians and surgeons who become involved in discovery deposition procedures.

Rule 204 of the Illinois Supreme Court states that, "The clerk of the court shall issue subpoenas on request, EXCEPT THAT SUBPOENAS FOR THE DISCOVERY DEPOSITIONS OF PHYSICIANS AND SURGEONS MAY BE ISSUED ONLY UPON ORDER OF COURT." The Rule in its entirety follows:

RULE 204—Compelling Appearance of Deponent

- (a) *Action Pending in This State*. The clerk of the court shall issue subpoenas on request, except that subpoenas for the discovery depositions of physicians and surgeons may be issued only upon order of court. The subpoena may command the person to whom it is directed to produce documents or tangible things which constitute or contain evidence relating to any of the matters within the scope of the examination permitted under these rules. Service of notice of the taking of the deposition of a party or person who is currently an officer, director, or employee of a party is sufficient to require the appearance of the deponent and the production of any documents or tangible things listed in the notice.

The Supreme Court Committee which revised the rules comments that: "A new provision, (Rule 204) makes an order or court a prerequisite to the issuance of a subpoena to the discovery deposition of a physician or a surgeon."

This new rule means that all discovery deposition subpoenas for physicians and surgeons must be approved by the "motion judges" of the Illinois Circuit Court before they are served on physicians and surgeons.

Prior to the adoption of the new rule subpoenas were issued by the clerk of the court on request of the attorneys involved in the litigation. This procedure resulted in actions that were considered abusive to physicians and surgeons. The new rule will tend to eliminate abuses prevailing under the previous rule to the extent that the attorneys involved will exercise more restraint in subpoenaing physicians and surgeons inasmuch as the judge must sign the order for the subpoena requiring the deposition of a physician or surgeon.

The Medical-Legal Committee suggested that the medical society officially acknowledge this rule change and convey its official appreciation of the added consideration for physicians and surgeons to the individual members of the Illinois Supreme Court. This has been accomplished.

The committee continues to maintain effective liaison and rapport with the Medical Cooperation Committee of the Illinois State Bar Association. Presently the joint committees are studying:

1. revisions of the "Inter-professional code for Lawyers and Physicians."
2. professional liability panels in operation in various states.

Luis V. Amador, *Chairman*

Joseph Ankenbrandt John G. Meyer, Jr.
Clinton L. Compere George C. Turner

COMMITTEE ON LABORATORY EVALUATION LP-4

Your Laboratory Evaluation Committee acting to fulfill the responsibilities assigned to it by the House of Delegates has concerned itself the past year mainly with activities evolving from the passage of the "Illinois Clinical Laboratory Act". This act, passed by the 74th General Assembly, effective August, 1965, licenses and regulates the operation of clinical laboratories in Illinois. Directed principally to the licensure of the commercial clinical laboratory, the act contains the following exclusions:

"Sec. 1-103. This Act applies to clinical laboratories and directors of clinical laboratories except that this Act does not apply to:

- a. Clinical laboratories operated by the U. S. Government and the State of Illinois.
- b. Laboratory facilities and laboratory serv-

ices operated by a hospital licensed under the "Illinois Hospital Licensing Act."

- c. A person licensed under the Illinois Medical Practice Act or under the Illinois Dental Practice Act whose operation is limited to laboratory analyses performed for his own patients within the scope of his license. Provided, however, that if the laboratory receives direct or indirect referral work from any source, all provisions of this Act shall apply."

The Clinical Laboratory Act, designed to license the facility, establishes categories of persons eligible to operate a clinical laboratory.

A check with the laboratory evaluation section of the Illinois Department of Public Health revealed that a high percentage of the laboratories, subject to coverage of the Act, are presently licensed. In some situations, extenuating circumstances prevented early licensure of the facilities.

As an outgrowth of the resolution of the Illinois Society of Pathologists, pertinent action of the House of Delegates of 1966, and present policy of the Illinois State Medical Society, the state medical society will sponsor legislation amending the Clinical Laboratory Act to restrict the operation of the clinical laboratory to a physician licensed to practice medicine in all of its branches. (The statements previously referred to state that the "operation of clinical laboratory is considered to be the practice of medicine".) The proposed amendment to Section 6-101 of the act will read as follows:

"Every clinical laboratory shall be under the supervision and direction of a director who possesses one of the following qualifications:

- a. He is a pathologist licensed to practice medicine in all of its branches in Illinois, certified by the American Board of Clinical Pathology; or who possess qualifications acceptable to the Department and equivalent to such certification.
- b. He is a physician licensed to practice medicine in all of its branches in Illinois or a Dentist licensed to practice in Illinois with special qualifications in the performance of test or tests offered by the clinical laboratory whose qualifications are acceptable to the Department."

Reference to persons presently eligible to operate a clinical laboratory will be deleted. Section 7 will be amended to read:

"except as otherwise provided, a clinical laboratory shall examine specimens only at the request of a physician licensed to practice medicine in all of its branches or a person licensed under the Illinois Dental Practice Act."

The amended act will conform to the resolution of the Illinois Society of Pathologists and to the policy statements of the Illinois State Medical So-

ciety that the "operation of a clinical laboratory is considered to be the practice of medicine".

The proposed amendment will be reviewed by the Legislative Committee after study and concurrence by the Laboratory Evaluation Committee.

The committee has presently under study the "conditions for coverage of services of independent laboratories" as prepared by the U. S. Department of Health, Education and Welfare for the implementation of P.L. 89-97 (Medicare).

The Illinois Department of Health reports that commercial laboratories will have blanket approval for reimbursement until April 15, 1967, at that time each laboratory eligible for reimbursement will be so certified by the Illinois Department of Health.

The committee has under consideration the activities of two laboratories which provide patient laboratory service by mail. Questions raised concerning these two facilities are (1) the activity in relation to the current standard of medical practice; (2) the activities in relation to the provisions of the Illinois Clinical Laboratory Act.

The committee wishes to call the attention of the House to the surveys of clinical laboratories that have been taken nationally which reveal a high percentage of error in the analysis of samples submitted. Concerned that the physician and the patient receive the most accurate information, the committee urges caution in the use of laboratories and the exercise of sound judgment in obtaining the most accurate analysis possible. It would seem likely that the most accurate analysis of specimens would originate in laboratories directed by physicians qualified in the laboratory disciplines.

Individual physician should concern himself with the specimens to obtain the most effective end product for diagnosis and care of the patient.

Your Committee on Laboratory Evaluation shall continue to exercise surveillance of activities relating to clinical laboratories and will inform the House of its findings.

James B. Hartney, *Chairman*

Thomas P. de Graffenreid

Jack Williams

Grover L. Seitzinger

Hans Willuhn

COMMITTEE ON NARCOTICS & HAZARDOUS SUBSTANCES LP-5

Your Committee, focusing exclusively on the subject of narcotic addiction, has maintained the momentum established with the presentation of the ISMS Conference on Narcotic Addiction in 1966. The symposium was published in the October issue of the *Illinois Medical Journal*. As bi-products of the conference, five narcotic task forces were established to ensure coverage and continuity of study of the principle problem areas of narcotic addiction. In addition to the ISMS Committee on Narcotics, the members of the

task forces included representatives of the U. S. Bureau of Narcotics, Illinois Division of Narcotic Control, Drug Abuse Control Division of the Food and Drug Administration, Illinois Department of Mental Health, Metropolitan Welfare Council, Illinois Narcotic Advisory Council, Council for the Understanding and Rehabilitation of Addicts, the Circuit Court (narcotic) and the Chicago Police Department.

The committee has acted as the main gear of a mechanism that has established liaison and developed effective interaction with the organizations listed above. These organizations which have specific responsibilities relating to the narcotic addiction problems are now working in concert with the medical community to: (1) study the problems of narcotic addiction as they relate to Illinois; (2) analyze the epidemiology of addiction; (3) determine the profiles of addiction; (4) create an awareness of the enforcement problems of addiction; (5) review the sociological problems; (6) identify roles of community organizations in combatting addiction; (7) determine economic impact of addiction on a community; (8) obtain census of crimes relating to addiction; (9) explore drug stabilization programs for addicts; (10) obtain data on experimental approaches to addiction treatment, and community rehabilitation programs; (11) determine addiction problems of physicians and para health personnel; (12) achieve coordination of state, municipal, and voluntary programs to combat narcotic addiction.

The role of the Illinois State Medical Society as the working mechanism of interaction of these various organizations involved in combating narcotic addiction problems was praised at a recent conference on drug abuse sponsored by the American Medical Association. The basic objective of the AMA Conference on Drug Abuse was to reveal to the states with high addict population: (New York, Pennsylvania, California, Michigan, and Illinois) activities in the respective areas that would be worthy of the adoption in other jurisdictions. It was noted by the conferees that the Illinois State Medical Society had created a pattern of activity, maintaining interaction among the various organizations disciplines and individuals which has proved fruitful.

This interaction has been of immeasurable value to the total community. Representatives of the organization have appeared individually and as panel participants in narcotic programs, before scientific, educational, fraternal, civic, academic and municipal groups within the state. One academic presentation initiated by the ISMS Committee on Narcotics was a symposium on drug abuse given to the medical students of the Northwestern Medical School. Intended primarily for the senior medical students, it attracted students from all of the classes of the medical school. Student comments in-

cluded "informative, interesting, fine program." The committee plans to hold similar symposiums each year for the senior medical students at Northwestern University Medical School. It is the hope of the committee that identical programs can be presented in other medical schools throughout the state.

In liaison with the ISMS Committee on Narcotics, the Illinois Narcotic Advisory Council, of which the chairman is a member, has developed legislation that will establish programs for the care, treatment and rehabilitation of narcotic addicts in Illinois. Essentially, the program is one of addict commitment to treatment program in lieu of prosecution of criminal action. Certain addicts are excluded from participation in this program. These include addicts who have committed acts of violence, addicts who are sellers of narcotic drugs, and habitual criminals. The program administered jointly by the Illinois Department of Mental Health and the Illinois Narcotic Advisory Council will be in essence a pilot program in a selected area of Chicago with high addiction population. It will undertake the various approaches to treatment of addicts that are now known to be therapeutically valid.

The committee, noting that the effective date of the federal "Narcotic Addiction Act of 1966" was Feb. 8, 1967, arranged a meeting with representatives of the agencies responsible for implementation. Invited to the meeting were: Hon. William Campbell, Chief Judge, U. S. Federal Court, Northern District of Illinois; Richard P. Stein, U. S. Attorney, Indianapolis; Harold Visotsky, M.D., Director, Illinois Department of Mental Health;

Edward V. Hanrahan, U. S. Attorney, Northern District of Illinois; Vernon Forney, D.D.S., Director, U. S. Public Health Service; and Charles Ward, U. S. Bureau of Narcotics. Discussion of the provisions of the act proved highly beneficial for all parties.

Additional legislation has been introduced in the 75th General Assembly to include LSD-DMT (d-lysergic acid diethylamide and dimethyltryptamine) under the coverage of the "Uniform Drug Device and Cosmetic Act." This act imposes statutory controls on all drugs potentially dangerous and which are not appropriate for self medication. The medical society strongly supported controls on the two hallucinogens. Your chairman appeared as a witness before the Public Welfare Committee in support of the bill. The ISMS has been commended for the activities of the Committee on Narcotics by representatives of the judiciary, law enforcement agencies, state health agencies, municipal and civic organizations, and members of the 75th Illinois General Assembly.

Your committee is hopeful that the effort being expended to attack the seemingly insoluble problems of narcotic addiction will obtain meaningful results for medicine and for society at large.

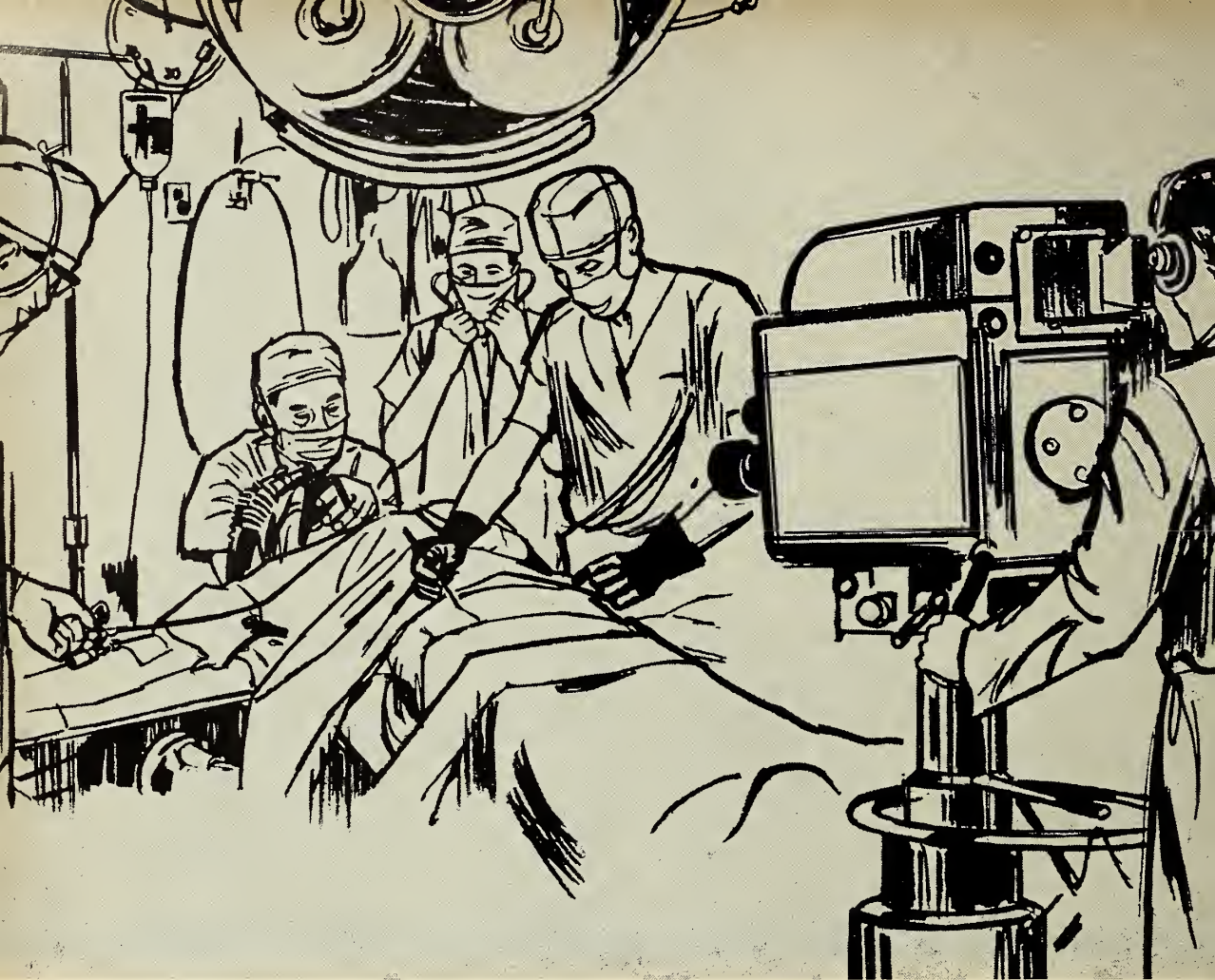
Joseph H. Skom, *Chairman*

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Kermit Mehlinger	Ross Schlich
R. K. Richards	George S. Schwerin
David M. Slight	

PUBLIC AFFAIRS COMMITTEE

LP-6

No report submitted.



Public Relations & Miscellaneous Business

COMMITTEE ON AGING PR-1

While the Committee on Aging has continued the projects originally set forth — e.g., implementing pilot programs in District I, encouraging active stroke programs, forming County Councils on Aging, and supporting rehabilitation training — it has added a dramatic new dimension to its programming for 1967.

The committee is planning to launch a continuing educational campaign on medical and socio-economic problems of the aging directed to the profession as well as the general public.

The project was launched last January with an *Illinois Medical Journal* article on Extended Care Facilities, followed by a 15-minute slide ECF presentation for use at the county and district meetings. The presentation was shown at the ISMS Fifth District meeting, the Winnebago Council on Aging, and the Chicago Clinical Conference. The Medical Society of the State of New York also requested a

copy of the presentation for its professional educational program.

The ECF story was then carried to the public by means of a five-minute television presentation on Station WBBM-TV, radio interviews on Stations WLS and WJJD, a five-minute "Medical Interview" program broadcast on 51 downstate radio stations, and a "Dr. SIMS Safeguard Your Health" newspaper column published in more than 300 downstate newspapers.

In its search for additional subject material for this project, the Committee is being aided by the Woman's Auxiliary.

"Stroke" Film in Demand

Meanwhile, the Committee's film, "Stroke—Early Restorative Measures in Your Hospital," continues to attract considerable interest, with 24 prints having been sold during the past year. Money from the film sales is donated to the ISMS Educational and Scientific Foundation.

In addition, the American Medical Association

scheduled 148 bookings during 1966, and the Illinois Department of Public Health reports receiving between 40 and 50 requests a month for its showing. The stroke film was also shown at the annual meeting of the Australian College of General Practitioners and booked on a three month tour of universities and hospitals in Colombia by the Association of Faculties of Medicine in Bogota, Colombia.

During the year, the committee reviewed guidelines for the formation of Utilization Review Committees for Extended Care Facilities. The committee feels that utilization review is a program of study and education of particular interest to the physicians using the facility, but that one committee could fulfill both the Medicare review of cases of extended duration and perform the educational service. Since all ECFs will not have staffs large enough to perform the review function internally, the committee recommended that county medical societies consider providing a community-based utilization review committee for all ECFs in the area.

The Board of Trustees approved the committee's request to provide assistance to county societies undertaking this service.

Consider TV Series

The committee is currently considering co-sponsorship of a 13-part television series with the Illinois Association of Homes for the Aged on Station WFLD, Chicago. Meetings are underway to develop program content and responsibility for the joint effort. We do not foresee an additional budget request for the project, as it is being underwritten by an outside source.

Meanwhile, the committee continues to serve actively on advisory councils and committees concerned with the problems of aging and chronic illness. One such group is the Illinois Coordinating Committee on Chronic Illness, which is a 14-member organization dedicated to improving the teamwork necessary to provide medical, social, and economic aid to the chronically ill.

The committee wishes to acknowledge the splendid services of the Public Relations and Economics staff and Walter R. Livingston, committee consultant, for their assistance and cooperation in the work of this committee.

This is a report of progress and no action is required by the Reference Committee.

William K. Ford, *Chairman*

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WOMAN'S AUXILIARY:

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ARCHIVES COMMITTEE PR-2

Your Archives Committee continues its activities relating to the systematic retention, cataloging and placement of the documents, official records, and memorabilia that reveal historically the activities of the Illinois State Medical Society. Contact was made with several of the larger state medical societies to determine methods employed for preserving archives pertinent to their societies. The objective of the survey was to determine what methods may be employed by ISMS to improve efficiency in processing the archives of the society. As this is an on-going project, efforts will be directed toward the effective compilation and preservation of ISMS archives material.

A second subject of interest to the committee is that relating to the celebration of the Illinois Sesquicentennial in 1968. This is a statewide celebration encompassing not only the official state agencies, but also those of professional, vocational, civic, and municipal organizations. The committee has been in contact with Ralph Newman, chairman of the Illinois Sesquicentennial Commission to determine the role of professional medicine in the activities of the Sesquicentennial. Mr. Newman reported that several committees will be structured throughout the state to assist the commission in the presentation of activities relating to the history of Illinois. Mr. Newman suggested that a committee representing professional medicine be structured to assist the commission. This would be called the Medical Committee of 150. A similar committee would be formed by the Illinois State Bar Association called the Legal Committee of 150. Mr. Newman has requested that the state medical society forward membership of the Medical Committee of 150 to him for further action by the Sesquicentennial Commission.

Considering the two activities, (the Archives program and the Sesquicentennial) your chairman appeared before the Illinois State Medical Society Board of Trustees on Jan. 15 to present the following committee recommendations.

1) Appropriation of sufficient funds (\$2,000) for the planning required to create a historic, medical exhibit in Springfield in conjunction with the Sesquicentennial. This would be in no way related to the museum project previously considered by the House of Delegates involving an ISMS exhibit in the Old State Capital Building.

2) Sufficient appropriation (initially \$2,000) for planning the preparation of volume 3 of the "History of Medicine in Illinois."

3) The appointment of a statewide Sesquicentennial Medical Committee to work in conjunction with the Sesquicentennial Commission.

Upon hearing these recommendations of the Ar-

chives Committee, the Board of Trustees referred items 1 and 2 to the Finance Committee for study and recommendation. Your chairman had previously appeared before the Finance Committee to outline the projected expenditures of the Archives Committee for 1967. The board did not act upon the recommendation for the statewide medical committee. Appropriate action on this point will be taken by the board at its March meeting.

Further developments on these projects will be reported by your committee.

Emmet Pearson, *Chairman*

Carl W. Hagler Clifford E. Smith

Leo Zimmerman

COMMITTEE ON DISASTER MEDICAL CARE PR-3

The Committee on Disaster Medical Care held two formal meetings in 1966 and conferred frequently by telephone. The committee's major emphasis was placed upon three programs—Packaged Disaster Hospitals, Medical Self-Help, and fixed hospital disaster training.

Packaged Disaster Hospitals: Approximately 2,300 PDHs (formerly called Civil Defense Emergency Hospitals) are now established throughout the United States. Illinois easily leads the nation in PDH training programs, having pioneered in this type of training. To date, Illinois is the only state conducting practical training with disaster hospitals.

The committee's goal is to have at least three PDH training centers in the state. Two already have been established at Springfield and at Elmhurst. Drs. Jack Baldwin and Ford Van Hagen did an outstanding job with PDH training in the Douglas School at Springfield during the past year. Their initiative and aggressiveness in establishing a program has resulted in an excellent and informative training course.

The first training programs of 1967 are planned for April 9 and June 4 at Elmhurst's Memorial Hospital of DuPage County, the first U. S. hospital with an area specifically designed for a PDH. An underground PDH facility was completed and a 1962 model PDH was positioned there last November.

The training sessions will be sponsored by ISMS, the Illinois Civil Defense Agency, the regional office of the U. S. Public Health Service, the Illinois Department of Public Health, and the Memorial Hospital of DuPage County. Committee representatives met several times with officials of these organizations to help plan the training program. Numerous requests have been received from persons within the state—and from outside Illinois—to attend the programs.

The Committee is working for the establishment of a third training center to serve the south-

ern part of Illinois. The committee feels strongly that such a program is needed and that a center—perhaps in Carbondale—should be established for the storage of PDH and the training of personnel in its use.

Establishment of a fourth training center is being considered by disaster medical care personnel in Rockford. The committee has worked closely with the group to encourage their participation in the PDH program.

It should be understood that PDH training programs are a continuing project. The committee plans to present about four training sessions a year for an indefinite period.

Student manuals used in previous PDH training at Elmhurst's York high school are being revised, as are the instructor manuals. Both will be used in the training programs at Memorial Hospital of DuPage County.

Medical Self-Help: Illinois ranks second among all states in the number of persons trained in Medical Self-Help. The past year has seen a continuation of the committee's efforts in this area. A condensed version of the self-help training program was developed at the request of the Chicago office of the Internal Revenue Service. The IRS asked the committee to give a two-day presentation of the program for approximately 60 IRS employees who are responsible for disaster and emergency medical care. The program was so well received that the Commissioner of Internal Revenue sent the committee a letter of commendation. The presentation was also the subject of an article in an IRS newsletter. The condensed version of the training program will be retained for use should the committee receive similar requests from other groups.

Our Medical Self-Help films, which we produced in 1963, were sold to the Indiana State Medical Society and were shown on Station WTTV in Indianapolis early in 1967. A committee representative also presented summaries on Medical Self-Help before civic and hospital officials in Marathon, Fla.

The committee recommends continuation of the Medical Self-Help promotion. It feels that such promotion can be best accomplished through the medium of the PDH—that one program augments the other. When paramedical personnel study the PDH, they realize the great need for Medical Self-Help training to distribute the responsibility and burden of medical care through larger groups in a disaster. When the same personnel study Medical Self-Help, they see the need for the PDH for definitive care after a national disaster.

Fixed Hospital Disaster Training: The prototype hospital disaster manual developed by the ISMS and patterned after the hospital disaster manual of Memorial Hospital of DuPage County has enjoyed great success. Approximately 2,000 of the

manuals have been distributed to hospitals, medical organizations, and civil defense groups throughout the U. S. and in other nations. The demand continues. After each presentation of a hospital disaster planning program, new requests are received for copies of the manual.

At present, the Memorial Hospital of DuPage County Disaster Manual is being revised because of the expansion of the hospital. It has yet to be determined whether this will require a revision of the ISMS prototype manual. Should a revision be indicated, the committee will try to have the project underwritten by a hospital supply company or a pharmaceutical firm.

Hospital disaster planning programs were presented by committee representatives at Silver Springs, Md., Buffalo, N. Y., and Mansfield, Ohio, during the year. In addition, similar programs were presented for the professional nursing staff at Chicago's Wesley Hospital and for an incoming class of student nurses at Memorial Hospital of DuPage County. Disaster planning was also discussed by committee representatives on several radio and television programs in Chicago and Decatur.

Four lectures on disaster planning were presented by the committee chairman at the Institute for Disaster Planning in Washington, D. C., on Feb. 1. The Institute was sponsored by the American Hospital Association and the U. S. Public Health Service.

Other Committee Activities: Committee representatives held meetings with civil defense officials, representatives of the U. S. Public Health Service, the State Department of Public Health, and with representatives of various auxiliary and paramedical groups.

The committee worked with the Public Health Service in the editing of new manuals published by the federal government on disaster hospitals.

The chairman of the Committee on Disaster Medical Care commends all committee members who have participated with enthusiasm through the year—in some individual cases, for several years. It is also obvious that our work could not have been accomplished had it not been for the loyal support of the ISMS Public Relations staff.

Max Klinghoffer, *Chairman*

Jack R. Baldwin Harold C. Lueth

Richard V. Lee Carl F. Steinhoff

AUXILIARY REPRESENTATION:

Mrs. Victor H. Beinke

**FIFTY YEAR CLUB COMMITTEE
PR-4**

All previous attendance records were broken when 187 members and guests of the Fifty Year Club met for the group's annual luncheon on May 17, 1966, during the ISMS convention. This

attendance compared with 149 in 1965, 170 in 1964, and 163 in 1963.

In an effort to recapture those "wonderful" days of 1916 when the club's new members graduated from medical school, the Fifty Year Club took its members "down memory lane" with a unique program of slides, films, music and skits. Slides of the newly-initiated members were flashed on the screen as they received their emblems and certificates.

Most of the 46 members of the Chicago Medical Society who became eligible for membership in 1966 were initiated into the club; others who were eligible but could not attend received their certificates and emblems from ISMS trustees in the area.

In addition, some 39 downstate physicians were honored at meetings of their county medical societies. A special effort by the staff was made in furnishing news releases in connection with the 1966 presentations.

The total membership of the group now stands at an all-time high of 515 compared with a 503 a year ago. There were 73 deaths recorded among members during the year.

The 1967 luncheon meeting will be held Tuesday, May 23.

George F. Lull, *Chairman*

G. C. Otrich

Walter H. Theobald

**GRIEVANCE COMMITTEE
PR-5**

With the exception of some 49 cases still pending, all of the 447 complaints against ISMS physicians during the past year were settled on the local level by the county medical society committees.

Of the 41 county societies submitting annual reports, only nine found it necessary to process complaints.

Following is a tabulation of the reports, with the Chicago Medical Society considered apart from the smaller downstate societies which are tabulated as a group.

Chicago Medical Society

Number of complaints	418
Cases pending	47
Complaints referred to the Committee to Investigate and Consider Informal Charges of Unethical Conduct	5
Complaints referred to the Ethical Relations Committee	1
FEES (complaints involving fees)	169 (46%)
Doctors fees justified	135 (80%)
Fees not justified—reduced, cancelled or refunded, per recommendation of Grievance Committee	34 (20%)

Doctors reprimanded by Grievance Committee—not cooperative with Committee and/or refused to reduce bill, per recommendation of G. C.	11 (3%)
Unjustified criticism of doctors concerning treatment, diagnosis and/or general misunderstandings	72 (19%)
TOTAL CASES CLOSED AND FILED—1966	371
Complaints unjustified	326 (88%)
Complaints justified	45 (12%)
Downstate County Societies	
Number of counties reporting	40
Number of complaints registered	29
Breakdown of complaints	
(a) excessive fees	19
(b) service	11
(c) other (professional capability, personality conflict)	2
Manner of settlement	
(a) through satisfactory explanation	10
(b) through reduction in fees	4
(c) through other means	2
(d) cases pending	2
Physicians censured	5

The survey reveals 82 fewer complaints were filed this year than in 1965-66.

County medical societies must be aware that grievance cases must be heard initially at the county level. If the case is not resolved at this level, it is then referred to a district committee for a hearing and then to the state committee.

Since there is considerable overlapping of responsibilities between the Grievance and Ethical Relations Committees, we feel both committees should be studied for possible updating.

William H. Walton, *Chairman*

A. K. Baldwin	Frank H. Fowler
Allison L. Burdick, Sr.	Victor V. Rockey
Arkell M. Vaughn	

ADVISORY COMMITTEE TO THE HEALTH CAREERS COUNCIL OF ILLINOIS PR-6

The Advisory Committee to the Health Careers Council of Illinois is charged with the responsibility of advising HCCI on careers in medicine; assisting it in developing new financial resources; and keeping ISMS membership abreast of the need for health personnel.

A non-profit organization comprised of 23 health career groups—including ISMS—HCCI was established to serve as an authoritative information center on health occupations and as an effective mechanism for the conduct of career guid-

ance and recruitment programs. We are pleased to report that the council has performed admirably in this area, assisting in the guidance of more than 100,000 high school students each year.

With health personnel shortages approaching critical proportions, however, HCCI was forced to expand its services to include educational development and research projects, as well as recruitment—a program calling for an annual budget of \$144,800.

In embarking upon its expanded program, the council had hoped to gain the major share of its financial support from the health professions with \$60,000 expected from the Illinois Hospital Association, \$20,000 from ISMS, \$14,800 from other health professions and \$50,000 from foundations, industry, and business. Unfortunately, this has not proved successful.

While the Illinois Hospital Association met its obligation—and pledged \$60,000 annually for the next three years—ISMS has ignored its responsibility, thus blocking opportunities for foundation grants. Foundations—as well as business and industry—refuse to support HCCI because of the medical profession's refusal to contribute to its own cause. It is imperative, therefore, that ISMS take its place as the leader of the health team and assume the responsibility that goes with it.

If we continue to ignore the plight of HCCI, the council could be subsidized by the federal government or be forced to curtail operations. Should this happen, ISMS would have to assume a greater share of the responsibility for health career guidance and recruitment—at a cost much greater than \$20,000 a year. With the health personnel shortage as critical as it is, we would have no choice.

In Illinois hospitals alone, for example, there are currently over 6,000 vacancies for positions in allied health occupations. Critical as the problem is today, studies project an even worse situation with the demand for nurses, dietitians, medical technicians, etc., expected to double by 1975. Unless we can fill a great portion of these vacancies through recruitment programs of HCCI, existing health care standards for Illinois citizens will be seriously compromised.

As leaders of the health team, we cannot afford to let this happen. While hospitals are the primary employers of these personnel, we, as physicians, are heavily dependent upon them to help us carry out our responsibilities. We are obligated, therefore, to support the work of the council to the best of our ability. However the committee feels that ISMS has been somewhat remiss in its obligations to HCCI lately. For despite the council's impressive accomplishments and increased service to the health professions, ISMS has failed to increase its financial support of HCCI. The \$1,000 contribution allocated this year is the same as it has been the past four years.

Attempts to secure additional, voluntary contributions through membership solicitations have also failed. As a last resort, we appealed to the 1966 House of Delegates for an increase in our HCCI contribution. The House referred our request to the Board of Trustees with the suggestion that an increased contribution to HCCI be considered contingent upon the availability of reserve funds at the end of 1966. Apparently, the board did not find such available funds.

Instead, the board suggested we again direct our request to the House of Delegates with a definitive suggestion as to where these additional funds should be acquired.

The committee strongly urges the House to recommend additional funds be made available for the support of the Health Careers Council of Illinois through one of three means: (1) a \$2 increase in membership dues starting Jan. 1, 1968; or (2) allocating to HCCI \$2 of the \$20 our members currently contribute to AMA-ERF through existing dues structure; or (3) taking \$2 per member from the growing reserve fund for the next three years, contingent upon the continued good showing of HCCI.

Allison L. Burdick, Jr., *Chairman*

Jack L. Gibbs

Samuel B. Nelson

John B. Hall

Joseph C. Sodaro

ILLINOIS ASSOCIATION OF PROFESSIONS COMMITTEE PR-7

The Committee on the Illinois Association of Professions continues to be active in its relations with other professional groups. The Illinois Association of Professions as a corporate body continues to meet approximately every three months, and conducted its third annual meeting on Oct. 21, 1966. Some significant progress in the organization can be reported, especially in the area of co-operative legislative planning. Membership continues to be maintained at a reasonable level. However, it is hoped that additional members of the medical profession will join the organization at the modest dues of \$10 per year. Although Mr. Richards has resigned as Executive Administrator of the Illinois State Medical Society, he has been asked to continue to serve as the Executive Director of the Illinois Association of Professions on a temporary basis until a replacement is secured.

Our committee continues to have a subcommittee in liaison with the Illinois Interprofessional Council of the Health Professions. We are fortunate in that Dr. Andrew J. Brislen has been president of this organization during the past year, and our representatives have been most conscientious in their attendance at the monthly meetings.

This Council is at present exploring the possibility of obtaining a federal grant to finance the

study of what happens to the students who enroll in professional schools related to the field of medicine but do not complete their education.

This committee has now been assigned to continue liaison with the Illinois Pharmaceutical Association. For several years this committee attempted to secure the approval of a Code of Understanding with the Illinois Pharmaceutical Association. Although the code as presented to the 1966 House of Delegates was tabled, the committee has been asked by the Board of Trustees to review the code and present it again to the 1967 House of Delegates. It is anticipated that this will be done in the form of a supplementary report.

George B. Callahan, *Chairman*

Andrew J. Brislen

Edward A. Piszczek

James D. Majarakis

Vincent C. Sarley

Eugene L. Vickery

EX OFFICIO:

Michael R. Saxon

Robert L. Richards

Subcommittee - To Provide Liaison with Illinois Interprofessional Council of the Health Professions PR-8

Andrew J. Brislen, *Chairman*

Lawrence J. Bowness

Walter J. Reedy

James D. Majarakis

David Whitsell

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY PR-9

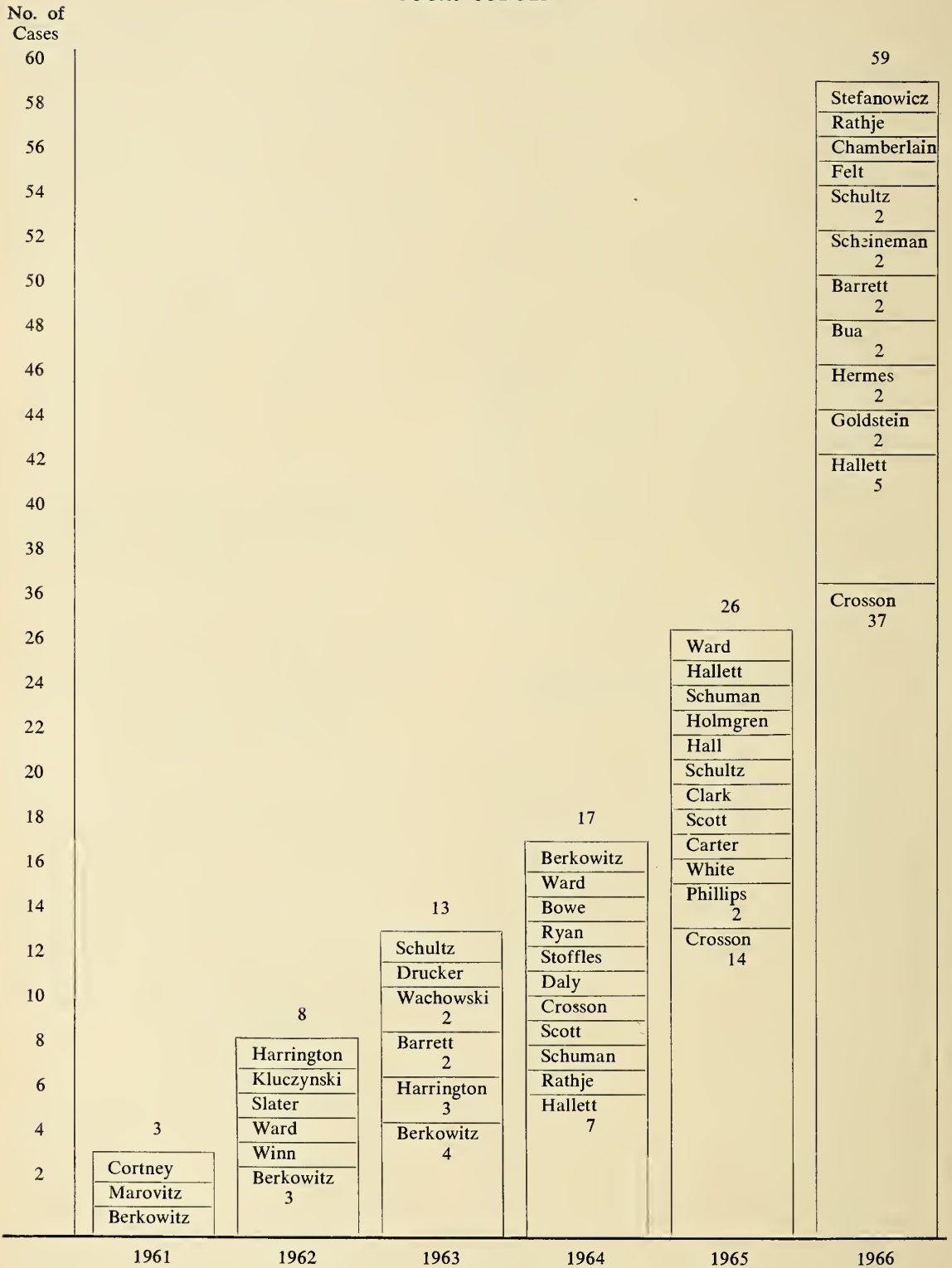
Your Committee is pleased to report that the incidence of impartial medical examinations as ordered by the Illinois Circuit Court judges in personal injury actions continues to expand at an increased rate over the previous year.

In 1966, Impartial Medical Testimony cases more than doubled those of 1965. Fifty-nine Impartial Medical Testimony medical examinations were performed by panelists voluntarily participating in the Impartial Medical Testimony Program. The attached chart shows the 1966 IMT case usage per judge.

Several interesting points are revealed in the compilation of IMT data. These are:

- 1) One judge (Crosson) invoked Illinois Supreme Court Rule 17-2 (Impartial Medical Examination) in 37 personal injury actions. This was 11 cases more than the 1965 total of 26 for all Circuit Court Judges.
- 2) Seven Circuit Court judges used IMT examinations for the first time. This is the average experience revealed in previous years when seven additional judges used it for the first time.
- 3) Thirty-four judges have employed IMT examinations.

IMT USAGE—ILLINOIS CIRCUIT COURT JUDGES



- 4) Seventy-eight percent of completed cases were settled pre-trial.
- 5) Sixty percent of cases were referred to orthopedic panelists (other medical specialties involved were: neurosurgery, neurology, urology, radiology, internal medicine, ophthalmology, otolaryngology, gynecology, cardiovascular, psychiatry).
- 6) Report to Illinois Judicial Conference (Hon. John Freels, Director, Administrative Office) states that "The comments of both judges and lawyers who have availed themselves of the program (IMT) have been quite favorable."
- 7) Based on the existing growth pattern and new judge usage, the IMT case projection for 1967 is 80 cases.

The Committee believes that the data supports the conclusion that the program is a sound one, operating effectively through the medium of the IMT reports to assist in the adjudication of personal injury cases.

The committee wishes to commend the IMT panelists for their objectivity and expertise in effectively processing the cases in which they participate.

The committee is greatly encouraged by the evidence of acceptance revealed in this report of progress of the IMT program in Illinois.

Clinton L. Compere, *Chairman*

R. Gregory Green	Jerome J. McCullough
Roger A. Harvey	Harry D. Nesmith
Samuel A. Levinson	Vincent C. Sarley
Maurice D. Murfin	Leo P. A. Sweeney

ADVISORY COMMITTEE TO ILLINOIS MEDICAL ASSISTANTS ASSOCIATION PR-10

The ISMS Advisory Committee to the Illinois Medical Assistants Association is pleased to report continued success of its program of cooperation with the IMAA.

Through our staff and advisory committee, we have rendered IMAA counseling, professional assistance and part time secretarial help in the implementation of the following activities:

- Editing, publishing and distributing its monthly newsletter, the "Executive Memo." This project is accomplished through the cooperation of Miss Sue Karels, IMAA president, and Mrs. Synobia Payne, president-elect.
- Preparing advance and follow-up news releases on members attending the annual convention, educational symposiums and other special events.
- Printing the officers and committee's annual reports, council meeting minutes, and special promotional pieces.
- Assisting in the publication of the IMAA

Quarterly Newsletter.

- Offering assistance in obtaining speakers for the annual convention and educational symposia.
- Obtaining a booth for the IMAA at the ISMS annual meeting.
- Printing IMAA appreciation notes and invitations.

IMAA has reimbursed the society for a good portion of such out-of-pocket expenditures as secretarial services, paper, printing, and plates used in IMAA projects. Services provided by the society's staff—such as our Public Relations Director, who serves as staff coordinator on all IMAA projects channeled through the society—are available without charge.

The IMAA advisory committee feels this program of assistance has greatly enhanced the relationship between the two organizations and will continue to do so by sustaining and implementing new projects of assistance.

Maynard I. Shapiro, *Chairman*

Carl Birk	Thomas R. Harwood
Donald E. Dick	H. H. Pillinger, Jr.
George Dohrman	Waldo C. Schneider
Earl W. Donelan	Fred L. Stuttle
Clarence G. Glenn	Paul G. Theobald

CONSULTANTS:

Carl E. Clark	Caesar Portes
Phillip G. Thomsen	

COMMITTEE ON OCCUPATIONAL HEALTH PR-11

Your Occupational Health Committee continues to (1) identify problem areas in Illinois peculiar to occupational health; (2) study the problem situations and ramifications; and (3) recommend appropriate solutions or satisfactory approaches to the problem conditions.

The committee persists in its actions supported by the Illinois State Medical Society House of Delegates to transfer the Industrial Hygiene Unit from the Illinois Department of Labor to the Illinois Department of Public Health. A resolution to this effect originated between representatives of the ISMS Occupational Health Committee and the Chicago section of the Industrial Hygiene Association. A letter was directed to Governor Kerner over the signature of the president of the Illinois State Medical Society recommending transfer of the Industrial Hygiene Unit. The Governor acknowledged receipt of the letter and indicated that he was holding his judgment until he had received the report from the Commission on State Government. It is the understanding of the Occupational Health Committee that the Commission on State Government will recommend action identical to that recommended by the ISMS.

In 1966 the Occupational Health Committee presented its second annual occupational health session in conjunction with the annual meeting of the Illinois State Medical Society. It was attended by over 100 physicians, nurses, industrial hygienists. The session emphasized the problems of alcoholism in industry and the medical aspects of workmen's compensation. The plan for the 1967 program includes the following subjects: "Industrial Hygiene in Occupational Health Programs"; "Job Placement," "Women in Industry"; "The Emotionally Disturbed Worker"; "Health Services for Small Employee Groups" and "Eye Health in Industry".

The Occupational Health Committee met with Dr. Edward Compere, Chairman of the ISMS Committee on Rehabilitation to discuss the present and projected coordination of state and county medical society committees with the Illinois Department of Vocational Rehabilitation. The liaison between these two committees will continue.

The Occupational Health Committee reviews annually the report prepared by the AMA which covers the activities of occupational health committees within the 50 states. An analysis of the individual state reports indicates that several items are worthy of further study by the ISMS Committee on Occupational Health.

Concerned with occupational health programs as they prevail in other areas, your chairman attended the International Occupational Health Congress which was held in Vienna, Austria. The conference revealed the varying degrees of occupational health achievement in the countries represented. Your chairman also attended the Congress on Occupational Health of the AMA in Portland, Ore. One of the features of this congress was a meeting of the chairmen of the occupational health committees of the 50 states. As an exchange mechanism for the promotion of effective occupational health programs the meeting was mutually beneficial. Several programs operating in other states are currently being studied by your committee.

The Committee on Occupational Health was requested by the Finance Committee of the State Medical Society to review ISMS policy concerning pre-employment physical examinations of ISMS employees and to make appropriate recommendations. The committee reviewed the pre-employment situation in the light of present policy which states that "The Illinois State Medical Society will provide a physical examination for all new employees. If your personal physician is a member of the state society we will accept his examination and pay appropriate charges." The personnel regulations within the society have placed a ceiling of \$25 per pre-employment physical examination.

The Occupational Health Committee suggests the following criteria for pre-employment physical examinations of ISMS employees.

1. Retain the requirement of a pre-employment physical examination.

2. Designate physician or physicians to control pre-employment physical examination program.
3. Devise suitable examination form (results of the examination would be reviewed by physicians designated to supervise the program).
4. ISMS should specify the type of examination.
5. Examining physician should report to ISMS history, physical, whether or not the individual is acceptable or not acceptable or classified (employment within designated capabilities).
6. The Occupational Health Committee recommended adherence to the standards for physical examination as included in the AMA publication "Guiding Principles of Medical Examinations in Industry". These are as follows:
 "... history, age, height and weight, and general appearance; skin, eyes, ears, nose, teeth and mouth, chest (lungs and heart), lymph nodes, peripheral blood vessels, abdomen including hernia, anus, genitalia, and spine and extremities; blood pressure, pulse, and temperature; urinalysis; and visual and hearing acuity. Personality, temperament, and significant nervous or mental manifestations should be noted."

The committee concurred with present regulations regarding the fee for the medical examination to the extent that it should be reasonable, not to exceed \$25. The committee accepted the point that in unusual cases involving difficult diagnosis the fee for examination should be based on the judgment of the physician.

The committee continues to make available to the occupational health committees of component societies and to individual physicians specialized occupational health pamphlets. These may be obtained by writing to the occupational health committee of the Illinois State Medical Society.

Edward C. Holmblad, *Chairman*
 Charles Asbury Arthur E. Sulek
 George H. Irwin Chester R. Zeiss

LIAISON COMMITTEE TO THE OSTEOPATHIC ASSOCIATION PR-12

This committee had no matters referred to it for consideration. The board requested that the committee not act without a specific assignment so no meetings were held.

Walter C. Bornemeier, *Chairman*
 Allison L. Burdick, Sr. Frank Fowler
 Harlan English Edwin S. Hamilton

PHYSICIANS' PLACEMENT SERVICE PR-13

During the past year, the Physicians' Placement Service was directly responsible for the placement of 20 physicians, one more than the previous year.

General practitioners were placed in the following downstate communities: Kewanee (2), New Baden, St. Rose, Lewistown, Abingdon, Buckley, Island Lake, Ottawa and Highland. In Chicago, placements were made at: the Callahan Clinic, Eastman Kodak Co., Blue Cross-Blue Shield, and the offices of Dr. T. S. Wright and Dr. George W. Tarry.

Specialists were placed in Arlington Heights (pediatrician), Springfield (surgeon and internist), and Chicago (two internists).

Actually, ISMS was responsible for many more placements which are unconfirmed as of this date. According to Mrs. Jane Swanson, Physician Placement secretary, it is becoming increasingly difficult to obtain verification of these placements by the physicians and communities.

The society contacts them periodically, but after they fail to respond to several follow-up letters, their names are removed from the active file. Occasionally, we find—months and even years later—that the listed vacancies were filled as a result of our efforts. One reason for this is that some registrants refer the information we have furnished them to associates; consequently, placements frequently result without ISMS being notified.

Meanwhile the demand, for general practitioners continues to increase by leaps and bounds, while the list of physicians available decreases at an alarming rate. Despite our efforts—and that of the Sears Roebuck Foundation—the shortage of general practitioners in some rural areas becomes more serious every day.

And if the demands of the military forces are to be met—and the trend toward specialization in metropolitan centers continues at the present rate—it is only a matter of time before the situation becomes critical.

In view of our increased efforts to assist rural areas, the situation is extremely discouraging. However, the problem of rural placement is not unique to Illinois, for medical societies throughout the country report similar problems.

What are other states doing to combat the situation? Mrs. Swanson, who attended the AMA's 1966 Conference on Physicians' Placement Services, reports the following:

- In Texas, the State Medical Society presents an annual day-long program to medical students on the advantages of rural practice and the opportunities it presents.

The result? Some 91 percent of the physicians who used the Placement Service report that it has been of assistance to them in making a decision on locating their practice, many of which are in rural areas.

- In Maryland, the medical society called the rural physician shortage to the attention of the state legislature. The legislature, in turn, established a nine man commission to study the problem.
- In Pennsylvania, the medical society is attempting to solve the problem by increasing its liaison program with medical students in the hope that they might attract them to non-metropolitan areas.

Meanwhile, here in Illinois we have placed a total of 683 physicians on the Placement Service mailing list during the past year, as compared to 904 last year, and 886 the previous year. Although 393 still receive our notices of openings, 290 have been removed because they have either found locations or have neglected to answer our follow-up letters.

We have publicized 453 opportunities during the last year, as compared to 426 last year and 364 the previous year.

A tabulation of physician-applicants and opportunities available as of Feb. 1, 1967 follows:

SUPPLY AND DEMAND OF PHYSICIANS AND
OPENINGS IN ILLINOIS AS OF FEB. 1, 1967

Specialties	Physician-applicants	Openings listed
General Practice	56*	222
Allergy	2	5
Anesthesiology	12	2
Dermatology	12	4
Eye-Ear-Nose-Throat	0	8
Internal Medicine	62	28
Neurological surgery	8	3
Obstetrics-Gynecology	25	7
Ophthalmology	15	11
Orthopedic Surgery	10	10
Otolaryngology	11	21
Pathology	20	2
Pediatrics	10	35
Psychiatry-Neurology	17	5
Radiology	14	1
Surgery	73	10
Urology	14	8
Miscellaneous	31	71
	393	453

* does not include student loan recipients

It should be noted that 222 openings for general practitioners are listed as of Feb. 15, 1967, but only 56 general practitioners were registered at that time. In 1956 there were 180 general practitioners on the mailing list and only 100 openings—an unfortunate comparison.

COMMITTEE ON PUBLIC RELATIONS PR-14

During the past year, the Public Relations Committee concentrated its efforts in four major areas: development of the society's corporate image; expansion of its health education programs; and assisting county medical societies overcome local PR problems.

Helping County Medical Societies

The most important phase of our 1966-67 public relations program was the increased service rendered to county medical societies in solving local PR problems.

The first "brush fire" which the committee extinguished occurred last summer in Rock Island where the physicians were severely criticized when an accident victim was brought into a hospital emergency room, treated and released without having been seen by a physician.

Public criticism snowballed and local newspapers, radio and TV were filled with editorials and stories denouncing the doctors for their negligence. While the attacks were unjust—the patients' injuries were merely superficial and the physician in charge directed treatment over the phone—the medical society was helpless against them.

At the society's request, we dispatched staff members to the area where they reviewed the situation and paid personal visits to every local newspaper editor, radio and TV news director to explain the physician's side of the story. Not only did it improve the county medical society's rapport with the media, but it resulted in blanket apologies from them for the embarrassment they caused the physicians.

To restore the local physicians' tarnished image, we outlined and implemented a full-blown, public education campaign on the community services provided by the local physicians. Needless to say, the media was happy to cooperate.

Through the efforts of our staff, we published a 13-part feature series in the Rock Island Argus and the Moline Dispatch newspapers on the public services rendered to the community by the county medical society, and persuaded TV Station WQAD to telecast a 13-week public service series on the same subject. The series featured local physicians, along with distinguished guests. Like the newspaper series, the scripts were prepared by the ISMS staff.

To promote the newspaper and TV series, we printed and distributed 12" x 18" posters for display in reception rooms of local physicians and hospitals. The Rock Island County Medical Society acknowledged our efforts as an "outstanding and effective PR program."

The second "brush fire" which we helped quell occurred in Richland County when LIFE magazine published a cover story in its June 18 issue accusing

Olney's Weber Medical Clinic physicians of allegedly "profiteering" from patients by forcing them to purchase drugs from the clinic-owned pharmacy. The accusations were attributed to the Illinois Pharmaceutical Association which had filed a formal charge of unethical conduct against the physicians with ISMS.

As in the Rock Island case, members of the Richland County Medical Society (18 of the 20 members belong to the clinic) requested the assistance of ISMS.

Once again, we dispatched a representative to the area where he surveyed the situation . . . met with newspaper editors, radio news directors and community leaders . . . and outlined a PR program for the physicians. The result? The clinic was deluged with more than 100 letters of support from community-minded citizens . . . the local newspaper published a strong editorial praising the doctors . . . and the community as a whole, united behind them in an effort to clear their names.

When the Eighth District Ethical Relations Committee formally declared the physicians innocent of the alleged charges, the PR Committee set about to restore their image. The committee did so with:

1. A letter to LIFE demanding a public apology on behalf of the Weber Medical Clinic.
2. Issued a press release to over 300 newspapers, radio and TV stations announcing the findings of the committee and our demand for an apology from LIFE;
3. Placed ISMS President Dr. Caesar Portes' and Ethical Relations Committee Chairman Dr. Willard Scrivner on Radio Stations WVLN, Olney, and WSOY, Decatur, to defend the physicians and praise them for their work.
4. Published stories in the ISMS newsletter "PULSE", as well as in all county medical society bulletins proclaiming the findings of the committee.
5. Outlined a long-term local PR program for the Weber Medical Clinic.

New Broadcast Record

For the fifth consecutive year, our radio-TV speakers bureau, films and recordings set a broadcast record as ISMS compiled over 575 hours of public service broadcast time—or 25 full days of airtime during the year.

In terms of dollars and cents, the \$9,500 invested in radio-TV production and services brought the society over \$500,000 worth of public service airtime—or about \$52 airtime for every dollar invested.

In establishing this record, we placed over 100 different physicians on almost every interview program in the Chicago area, as well as in Springfield, Decatur, Rock Island and Moline. However the bulk of our broadcast time was compiled throughout the state on programs produced by ISMS itself. They include:

- *Dr. SIMS TV Health Tips*, daily, 20-second health slide messages on preventive medicine.
- *Dr. SIMS Radio Health Tips*, daily 30-second health messages similar to the above. During the past year, these were broadcast over 30,000 times by 56 Illinois stations. Chicago Station WLS alone broadcast them some 552 times for a total of \$25,000 in free airtime.
- *One-Minute TV spots* on arthritis quackery and Community Health Week. The CHW spot featuring NBC-TV Star Lorne Greene, was telecast about 100 times during the year.
- *Medical Interview*, a weekly five-minute discussion on timely medical topics, pre-taped for broadcast on 56 radio stations.

Newspaper Features

One of the most important aspects of our health education program is the work done by Dr. Charles J. Weigel's Subcommittee on Newspapers.

This subcommittee is responsible for the preparation and distribution of the weekly "Dr. SIMS, Safeguard Your Health" column to the state's 700 daily and weekly newspapers and the unique "Dr. SIMS Talks to Teens" monthly health column to 300 high school publications.

This spring it will introduce a new feature—a health column to the labor force at Western Electric. The column—to be published monthly in a magazine called *The Relay-Ter*—will be the first of its kind to be published in an industrial magazine. It will focus on health and safety tips peculiar to the workers and will be seen by more than 10,000 workers at the Western Electric Co.

Community Health Week

Dr. Matthew B. Eisele's Subcommittee on Community Health Week produced one of its most successful CHW promotions ever in 1966.

In recognition of the growing shortage of health personnel, the subcommittee chose "Health Careers" as its theme to encourage young people to look into the opportunities existing in the health professions.

To call attention to the program, Dr. Eisele obtained the services of popular Hollywood star Lorne Greene of NBC-TV's "Bonanza." Mr.^a Greene proved an excellent honorary chairman.

Unlike so many stars who merely lend their name to such events Mr. Greene actually devoted several days work to our promotion by—recording public service radio spots—filming a one-minute TV spot—participating in our five-minute Medical Interview radio show—and addressing our Community Health Week Kickoff Breakfast in September.

The CHW Kickoff Breakfast—co-sponsored by the Chicago Medical Society—was a huge success as some 115 representatives from ISMS, CMS, the voluntary health agencies, the Health Careers Coun-

cil of Illinois and other groups jammed the dining room of the Continental Plaza Hotel. These, along with a "Dr. SIMS Talks to Teens" column and a "Dr. SIMS, Safeguard Your Health" column, which appeared in over 300 newspapers, were part of our all-out information campaign aimed at:

- (1) Informing the public of the critical shortage of health personnel; and
- (2) Encouraging youth to explore the opportunities in health occupations.

ISMS honored Mr. Greene for his efforts by presenting him with the society's first Gold Stethoscope award at the Kickoff program.

While Dr. Eisele has put together some fine promotions in the past, the committee thinks his 1966 version was by far the most meaningful. First of all because of the significance of the theme. Secondly, because of the excellent cooperation we received from the Health Careers Council, the Health Improvement Association, the Illinois Council of Voluntary Health Agencies and even the Illinois Jaycees.

Work with Voluntary Health Agencies

Dr. Andrew J. Brislen's Subcommittee on Voluntary Health Agencies—established in June, 1966, to implement the American Medical Association policy of expanding liaison with voluntary health groups—continues its fine work with major Illinois VHA's.

Most of the subcommittee's liaison responsibilities are carried out through its membership in the Illinois Council of Voluntary Health Agencies, which ISMS helped to establish last year. ISMS holds an associate membership in the council.

Dr. SIMS at State Fair

For the third consecutive year, Dr. SIMS maintained an "office" at the ISMS exhibit during the 1966 State Fair in Springfield. Dr. SIMS—portrayed by a representative of the PR staff wearing a three-foot high plasticized head—once again attracted record-breaking crowds to the ISMS exhibit.

Part of the huge crowd that came to see Dr. SIMS during the 10-day program was attracted by a television promotion which we pioneered over Station WICS-TV. The promotion consisted of 15 one-minute commercial spots inviting the public to visit the ISMS exhibit.

Parents and children alike shook hands with the ISMS symbolic emissary in what amounted to the most successful state fair promotion in ISMS history. Dr. SIMS proved an ideal good-will ambassador as he distributed to youngsters some 10,000 balloons bearing the image and health message of Dr. SIMS. In addition, volunteers from the Sangamon County Women's Auxiliary helped distribute over 6,000 packets of health information materials to adults.

Medical Journalism Awards

To acknowledge outstanding achievements in medical journalism—and stimulate improved radio-TV-newspaper coverage of medical events—the committee conducted its third annual Medical Journalism Awards competition.

The program, which has received wide acclaim, attracted a record-breaking 170 entries.

The following winners received handsome, walnut plaques at a colorful awards dinner held March 11 at the Ambassador Hotel: Chicago Daily News (2), Chicago Sun-Times, Chicago Tribune, Metro-East Journal, Rockford Register-Republic, Danville Commercial-News, Waukegan News-Sun, Tazewell Courier, Hinsdale Doings, and Stations WHBF-TV (2), WFLD-TV, WBBM-TV, WJJD, WCFL, and WMBD.

Judges for the competition were provided by the Publicity Club of Chicago and included: Mrs. Dene Murray, American Association of Medical Assistants; Mrs. Nancy Newman, University of Chicago Hospitals and Clinics; Miss Elaine Katz, Hospital Research and Educational Trust; Jack Righeimer, University of Illinois Medical Center; James Stott, Presbyterian-St. Luke's Hospital; Lee Feldman, Cooper & Golin, Inc.; Mrs. Sara Barr Cohen, American College of Radiology; and Otha Linton, American College of Radiology.

Assisting them were ISMS representatives Drs. Robert Mendelsohn, Joseph Skom, Catherine Dobson and Lee Winkler.

Sex Education Record

Our most recent health education project is the Dr. SIMS' phonograph record titled "When Your Child Asks About Sex." Produced through the ISMS Educational and Scientific Foundation, it features the voices of Dr. SIMS (Dr. Max Klinghoffer) and the popular CBS radio personality, Mal Bellairs of Station WBBM. The record, to be sold for \$3.98, is expected to be on the market before the annual meeting.

Leo P. A. Sweeney, *Chairman*
Andrew J. Brislen Charles J. Weigel
Matthew B. Eisele Lee F. Winkler
CONSULTANT
Jacob E. Reisch

COMMITTEE ON PUBLIC SAFETY PR-15

The primary concern of the Committee on Public Safety for 1966-67 was the completion of the much publicized Blood Alcohol Study conducted by ISMS, Illinois Department of Public Health, Illinois Coroner's Association, and the Governor's Official Traffic Safety Coordinating Committee. This 12-month study started Jan. 1 and concluded Dec. 31, 1966.

Blood samples were taken by coroners from

Illinois traffic fatalities, including the drivers and occupants of motor vehicles, as well as pedestrians. The blood was then tested for alcohol and carbon monoxide content by the state laboratories.

The 12-month study showed that 41 percent of all fatalities—including drivers, occupants and pedestrians—contained measurable amounts of alcohol in their blood. Of these, 21 percent contained at least 0.15 grams (presumed legal intoxication) and 10 percent contained between 0.10 and 0.15 grams.

Urge Tightening of Law

Of the reported teenage fatalities (ages 15-20) some 34 percent showed evidence of alcohol in their blood, of which 13 percent contained at least 0.15 grams and 6 percent contained between 0.10 and 0.15 grams.

As a result of these findings, the committee strongly urged and supported the proposed legislation which would change the definition of intoxication as expressed in terms of the blood's alcoholic content. At present a person with 0.15 grams percent of alcohol in his blood is "presumed to be under the influence of alcohol." The present bill recommends this figure be lowered to 0.10 grams.

The committee has received much publicity on this year-long blood alcohol study. Dr. Julius Kowalski and Dr. Norman Rose presented the six-month statistics at a press conference in ISMS headquarters on July 7. In addition, more than 100 newspapers carried the results; several newspapers wrote editorials commending the study; and committee members appeared on radio and television in behalf of this project.

Supports "Implied Consent" Bill

In addition to the blood alcohol study, the committee also:

1. Supported the "Implied Consent" Bill which gives the state the right to have blood drawn from anyone with a driver's license suspected of driving while under the influence of alcohol. At the time of this writing the bill has passed three Senate readings and has been sent to the House.

2. Urged the "Medical Review Board" legislation which would establish a board of physicians to consider physical and mental disabilities of drivers and make recommendations to the Director of Public Health regarding the individual's ability to safely operate a motor vehicle.

3. Endorsed the proposed legislation recommending the annual inspection of motor vehicles.

4. Requested legislation requiring that certain drugs be labeled "this may interfere with driving ability."

5. Cooperated with the Illinois Drivers Educa-

tion Association in supplying physician-speakers for high school drivers education courses. Various committee members appeared before high school driver classes emphasizing the need for driving safety, especially the alcohol problem.

Supported Crash Injury Study

6. Continued support of the Cornell University Accident Crash Injury Research (ACIR) Project by contacting more than 2,000 physicians who were asked to cooperate.

7. Engaged in the follow-up of the 1966 eye injury surveys conducted by the Illinois Society for the Prevention of Blindness. The purpose of this survey was to determine the frequency and source of Illinois eye injuries.

8. Authorized Chairman Kowalski to represent ISMS at a day-long Governor's Conference on Traffic Safety held Nov. 28, 1966. The conference primarily concerned itself with the proposed safety legislation introduced at the 1967 legislative session.

9. Dr. Sullivan represented ISMS at the AMA Public Safety Conference Feb. 3 and 4 in Chicago.

The committee expresses gratitude to James R. Slawny and Miss Susan Piszczek of the Public Relations & Economics Division for unusual diligence and extraordinary efforts in assisting this committee throughout the year.

Julius M. Kowalski, *Chairman*

James J. Callahan	Edwin A. Lee
James P. Campbell	Edward Press
Clarence E. Cawvey	Norman J. Rose
Dominic T. Chechile	Clifford P. Sullivan
George H. Irwin	Franklin D. Yoder

AUXILIARY REPRESENTATION:

Mrs. Ralph N. Redmond

**COMMITTEE ON REHABILITATION SERVICES
PR-16**

The Committee on Rehabilitation did not meet up to the time this report was submitted for publication. However, its members were special guests at meetings held by other organizations concerned with rehabilitation.

The chairman spoke before the Medical Advisory Committee of the Illinois Division of Vocational Rehabilitation at its annual meeting in December. He described in detail the ISMS Committee's ongoing efforts to compile a "Guide to Rehabilitation Facilities in Illinois, Listing Types of Disabilities Amenable to Rehabilitation." He suggested that all physicians who serve on rehabilitation committees should tour a rehabilitation center. The Division of Vocational Rehabilitation is organizing a one day in-service program for the members of its Medical Advisory Committee as a result of this recommendation.

The committee recognizes the necessity of working more closely with the Division of Vocational Rehabilitation in view of the scope of its services. The division provides most of its services through private sources, such as doctors, hospitals, and schools.

Members of this committee attended the awards banquet of the Governor's Committee on Employment of the Handicapped. Your committee wishes to commend this group, led by Dr. Frank Jirka, in its demonstrated concern with helping the handicapped attain economic self-sufficiency.

In the event the committee has recommendations for the House of Delegates to consider, a supplementary report will be filed.

Edward L. Compere, *Chairman*

Henry Betts	Joseph A. Petrazio
Brian Huncke	Arthur Rodriguez
Joseph L. Koczur	Howard Schneider

CONSULTANTS:

Frank J. Jirka	Reuben Wasserman
Walter R. Livingston	

**COMMITTEE ON RELIGION AND MEDICINE
PR-17**

The year 1966 saw an acceleration of activities by the Committee on Religion and Medicine. The committee is confident that programs initiated in the past year will flourish in the current year, and will contribute significantly to the achievement of the committee's assignment.

That assignment is the promotion of a continuing meaningful and working relationship between clergymen and physicians in their mutual concern for the spiritual and physical needs of the patient.

Projects now underway include:

1. A radio series. Scripts have been completed for 13 radio programs on subjects for which there is a particular need for understanding between physicians and clergymen. Terminal illness, therapeutic abortion, autopsies, alcoholism, euthanasia and narcotic addiction are among the program topics. Programs will open with a five-minute dramatization of the subject and conclude with a 10-minute discussion between a physician and a clergyman. The series will be offered to radio stations on a public service basis.

2. Publication of articles in the *Illinois Medical Journal* on religion and medicine topics. Articles are planned as a monthly feature and will be written—in most instances—by committee members.

3. Exhibits. For the first time, the committee will have an exhibit at the 1967 Annual Meeting of ISMS. Its purpose is twofold—to tell doctors about the committee, and to gain their support of the committees objectives through participation on

county medical society religion and medicine committees. It is the committee's hope that the exhibit will stimulate the formation of such committees in counties without them.

4. Religion and Medicine Literature. The Committee feels that it should serve as a reference source for published material on religion and medicine subjects. To that end, it is compiling a bibliography of source material for distribution to county medical society committees and other interested groups.

5. Awards Program. Tentative plans have been approved establishing an awards program to give recognition to clergymen or lay individuals who make outstanding contributions in the field of religion and medicine.

6. Clergymen on Scientific Panels. The committee believes it worthwhile to encourage the inclusion of clergymen on programs sponsored by the ISMS—when clergyman participation is appropriate. It is hoped that the chairmen of the scientific sections will give particular attention to this suggestion when they plan their programs for the ISMS annual meetings.

7. County society committees. The committee is agreed on the desirability of having more Committees on Religion and Medicine at the county medical society level. Several counties have already formed committees and it is the state committee's intention to pursue various avenues in its attempts to encourage other county societies to do the same.

The committee is grateful for the support and cooperation given to it in the past year by the Catholic Archdiocese of Chicago, the Church Federation of Greater Chicago and the Chicago Board of Rabbis. Representatives of these organizations—which encompass the three major religious faiths—were granted full membership privileges on the committee last year and have added immeasurably in helping to advance the committee's programs.

The Woman's Auxiliary to ISMS has also enthusiastically supported the committee. It has established an ad hoc committee on Religion and Medicine and has assured the committee of its readiness to lend its talents wherever possible.

Robert S. Mendelsohn, <i>Chairman</i>	
Anna Marcus	Morris Rothenberg
Bertram Moss	Harold Shinall
Charles W. Pfister	Ernest Teagle
Paul S. Rhoads	Otto Weiss

CONSULTANTS:

J. Ernest Breed	Caesar Portes
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AUXILIARY REPRESENTATION:

Mrs. Sherman Arnold

CLERGY:

Rev. Christian Hovda	Rev. Randall Mason
Rev. John Marren	Rabbi E. H. Prombaum

ADVISORY COMMITTEE TO STUDENT AMA PR-18

The committee's major project this year was a SAMA symposium held Feb. 10 at the Sherman House featuring John Millis, Ph.D., co-author of the controversial "Millis Report" on graduate medical education. Dr. Millis, president of Western Reserve University, was chairman of the Citizens Commission on Graduate Medical Education, which was established by the American Medical Association to explore ways in which high standards of medical education can be maintained.

The Stritch School of Medicine SAMA Chapter was the host for the symposium, attended by more than 100 students, medical society representatives and medical school deans.

To further acquaint SAMA members with the principles of organized medicine and to assist them with their chapter projects, the committee also:

- Produced a SAMA promotional brochure to increase chapter membership. The brochure lists the chief benefits of SAMA membership, including low cost life insurance, black bag and equipment insurance, and a subscription to the *New Physician*, the official SAMA publication.
- Invited chapter presidents to attend ISMS Board of Trustees meetings to familiarize them with the workings of organized medicine.
- Continued support of SAMA chapter programs by printing chapter and auxiliary newsletters.
- Outlined a program with the Chicago Board of Education in an attempt to get SAMA members active in Head Start projects with school children in clinic work.
- Offered financial assistance to SAMA headquarters for the national convention to be held in Chicago. The committee approved sponsoring free bus service between the five Chicago medical schools and the convention site. The committee strongly feels that this service will increase meeting attendance from Chicago area students.

Wright Adams, *Chairman*

Edward J. Krol	Norbert Metz
Louis R. Limarzi	David B. Radner

CONSULTANT:

William E. Adams

Resolutions

RESOLUTION NO. 67M-1

Introduced by: Kane County Medical Society
Subject: Membership in the House for other than Elected Delegates
Referred to: Reference Committee on Constitution & Bylaws

WHEREAS, The truly representative character of the House of Delegates of the Illinois State Medical Society resides in the delegates elected by their constituent medical societies; and

WHEREAS, Many issues of a controversial nature must be decided by a majority vote; and

WHEREAS, A substantial number of votes are cast by members of ex-officio status such as past presidents; and

WHEREAS, These votes do not represent a specific membership body, Now therefore be it

RESOLVED, That the Bylaws of the Illinois State Medical Society be amended to provide that only delegates elected and representing the membership in the ratio provided by the constitution of the Illinois State Medical Society be qualified to vote.

RESOLUTION NO. 67M-2

Introduced by: Lake County Medical Society
Subject: Physician's authority re: Nursing Home Calls
Referred to: Reference Committee on Economics & Insurance

WHEREAS, Under the law patients in an accredited nursing home must have a visit from the attending physician on a monthly basis, and

WHEREAS, It is felt that the attending physician is in a much better position to determine the medical visits necessary, and

WHEREAS, The demands aforementioned are an infringement on the practice of clinical medicine; therefore be it

RESOLVED, That the Illinois State Medical Society through the American Medical Association make efforts to return the decisions of medical practice to the physician involved.

Adopted: Lake County Medical Society, Feb. 8, 1967

RESOLUTION NO. 67M-3

Introduced by: Lake County Medical Society
Subject: Care of Patients under Title XIX PL 89-97
Referred to: Reference Committee on Economics & Insurance

WHEREAS, The American Medical Association adopted a resolution (substitute for Resolution 56) in November 1965 stating,

"Resolved, That the Board of Trustees continue to seek through all appropriate means, the implementation and administration of federal medical and health programs other than those of the armed

forces and Veterans Administration by the Surgeon General of the Public Health Service, and especially those programs under Title XIX of Public Law 89-97, and

WHEREAS, The Illinois State Medical Society adopted Resolution 66M-48 in May 1966 which called on the House of Delegates to respectfully petition the Honorable Otto Kerner, Governor of the State of Illinois, to designate the Illinois State Department of Public Health as administrative agent of the medical portion of Title XIX, Public Law 89-97, and

WHEREAS, The Lake County (Illinois) Medical Society questions the wisdom of these resolutions for the following reasons:

1. Welfare programs tend to lose their identity as *welfare* when administered in departments other than welfare, such as departments of public health.
2. As identity is lost, there is a tendency to expand programs under the guise of public health.
3. Legislators find it difficult if not impossible to object to the expansion of public health programs and activities.
4. As the programs expand and budgets become larger, the onus of increased expense may be placed on the physician, resulting in pressure to reduce fees or maintain fees at a low level. The result ultimately may be a system of fixed fees set at the national level and a greatly expanded number of physicians employed by government on a salaried basis providing medical care: therefore be it

RESOLVED, That the Illinois Delegation to the House of Delegates of the American Medical Association be instructed to introduce a resolution at the June 1967 meeting of the AMA calling for a re-examination of the AMA position; and be it further

RESOLVED, That the Illinois State Medical Society go on record as urging that welfare programs be positively identified as *welfare* and administered in welfare departments and not in departments of public health.

Adopted: Lake County Medical Society, Feb. 8, 1967

RESOLUTION NO. 67M-4

Introduced by: Lake County Medical Society
Subject: Personnel of Joint Commission on Accreditation
Referred to: Reference Committee on Publications & Scientific Services

WHEREAS, The Lake County Medical Society recognizes the importance of medical accreditation by physicians, and

WHEREAS, The Joint Commission on the Accreditation of Hospitals in the past has accomplished

this accreditation of hospitals, and

WHEREAS, The vast majority of medical care is dispensed beyond the confines of large medical centers; be it therefore

RESOLVED, That the Illinois State Medical Society through the American Medical Association recommend that qualified individuals outside of the medical centers be included on the commission, and be it further

RESOLVED, That the possibility of incorporating the American Academy of General Practice in the Commission be considered.

Adopted: Lake County Medical Society, Feb. 8, 1967

RESOLUTION NO. 67M-5

Introduced by: McLean County Medical Society

Subject: Certification & Recertification for Hospitalization of Medicare Patients

Referred to: Reference Committee on Economics & Insurance

WHEREAS, Section 1801, Title XVIII, of Public Law 89-97 clearly states, "nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or to exercise any supervision or control over the administration or operation of any such institution, agency, or person", and

WHEREAS, Various officials of the Department of Health, Education and Welfare have been ambiguous and evasive in their interpretation as to what constitutes certification and recertification of Medicare patients, and

WHEREAS, Various hospitals have adopted by administrative action, a specific certification form and are compelling members of their clinical staffs to sign this form for medicare patients, and

WHEREAS, Such requirements of certification and recertification of "Medical Necessity" for hospitalization of medicare patients does deviate from the ordinary procedure followed in providing hospital care to all patients, and

WHEREAS, Compliance by staff physicians with such a requirement would establish the precedence of Federal Bureaucratic control over the individual practice of medicine, set the medicare patient apart from regular patients in their admission procedure for hospitalization and have the effect of forcing physicians to participate in medicare against their will, and

WHEREAS, All hospitals and health insurance carriers have always accepted an admitting diagnosis, adequate history and physical examination, and periodic progress notes as proper documentation for need of hospitalization, and

WHEREAS, It is the desire of the members of the McLean County Medical Society to continue to serve all patients in need of hospital medical care in the usual and customary manner regardless of

whether such patients are medicare recipients, now therefore be it

RESOLVED, That the McLean County Medical Society advises its members to continue to support ethical and equal medical care for all patients and to record same, and advises its members to refuse to sign special certification and recertification forms or execute special statements of "Medical Necessity" for hospitalization of medicare recipients, and be it further

RESOLVED, That the McLean County Medical Society instructs its delegate to the ISMS to present a similar resolution to the House of Delegates of the ISMS at its next session and work to secure its passage therein.

RESOLUTION NO. 67M-6

Introduced by: Clark County Medical Society

Subject: Medicare Forms

Referred to: Reference Committee on Economics & Insurance

WHEREAS, There is an apparent misunderstanding on the part of the Illinois Department of Public Aid of the provisions of the so-called "Medicare Law" as to the right of the individual physician to deal directly with his patient or his patient's legally recognized agent in the payment for services rendered, and

WHEREAS, We hold the inviolability of the doctor-patient relationship to be of the utmost importance to the continued progress of medicine in the United States and this inviolability is threatened by the introduction of any third party between doctor and patient, be it hereby

RESOLVED, That the Clark County Medical Society inform the County and State Departments of Public Aid of the right of physicians to refuse to fill out the regulation Medicare forms for welfare patients and ask that they honor their obligations to any doctor who chooses to exert this right and instead directly bill IPAC, who then bills the agent for the patient. And be it further

RESOLVED, That the House of Delegates of the Illinois State Medical Society be asked to affirm the right of each individual physician to deal with the patient or his legally recognized agent directly rather than under any circumstances to be coerced into the filling out of the prescribed "Medicare" forms. And be it further

RESOLVED, that the House of Delegates of the Illinois State Medical Society be asked to inform both the Illinois Department of Public Aid and the appropriate ISMS committees of this action.

RESOLUTION NO. 67M-7

Introduced by: Clark County Medical Society

Subject: Certification & Recertification for Hospitalization of Medicare Patients

Referred to: Reference Committee on Economics & Insurance

WHEREAS, Section 1801, Title XVIII of Public

Law 89-97 clearly states, "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, —; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person; and

WHEREAS, Various officials of the Department of Health, Education and Welfare have been ambiguous and evasive in their interpretation as to what constitutes certification and recertification of Medicare patients, and

WHEREAS, Blue Cross and Continental Casualty, acting as agents of the government, interpreted this action of the Department of Health, Education and Welfare as requiring that certification and recertification contain the words, "Medically Necessary" and has so advised its participating hospitals, and

WHEREAS, Such requirements of certification and recertification of "Medical Necessity" for hospitalization of medicare patients does deviate from the ordinary procedure followed in providing hospital care to all patients, and

WHEREAS, Compliance by staff physicians with such a requirement would establish the precedence of Federal Bureaucratic control over the individual practice of medicine set the medicare patient apart from regular patients in their admission procedure for hospitalization and have the effect of forcing physicians to participate in medicare against their will and

WHEREAS, All hospitals and health insurance carriers including Blue Cross and Continental Casualty have always accepted an admitting diagnosis, adequate history and physical examination, and periodic progress notes as proper documentation for need of hospitalization, and

WHEREAS, It is the desire of the members of the Illinois State Medical Society to continue to serve all patients in need of hospital medical care in the usual and customary manner regardless of whether such patients are medicare recipients, now therefore be it

RESOLVED, That the Illinois State Medical Society advises its members to continue to support ethical and equality medical care for all patients and to record same, and advises its members to refuse to sign special certification and recertification forms or execute special statements of "Medical Necessity" for hospitalization of medicare recipients, and be it further

RESOLVED, That the Illinois State Medical Society condemns the requirement of special certification and recertification forms or statements of "Medical Necessity" and demands that the usual method of hospitalization for all patients be accepted, and be it further

RESOLVED, That the Illinois State Medical Society instruct its delegates to the American Medical Association to present a similar resolution to the

House of Delegates of the American Medical Association at its next session and secure its passage therein.

RESOLUTION NO. 67M-8

Introduced by: Crawford County Medical Society
Subject: Certification & Recertification for Hospitalization of Medicare Patients

Referred to: Reference Committee on Economics & Insurance

WHEREAS, Section 1801, Title XVIII of Public Law 89-97 clearly states, "nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, —; or to exercise any supervision or control over the administration or operation of any such institution, agency, or persons", and

WHEREAS, Illinois Blue Cross, acting as an agent of the government, interpreted this action of the Department of Health, Education and Welfare as requiring that certification and recertification contain the words "Medically Necessary" and has so advised its participating hospitals, and

WHEREAS, Various Illinois hospitals have adopted by administrative action, a specific certification form and are compelling members of their clinical staffs to sign this form for medicare patients upon threat of loss of admitting privileges for all patients, and

WHEREAS, Such requirements of certification and recertification of "Medical Necessity" for hospitalization of medicare patients does deviate from the ordinary procedure followed in providing hospital care to all patients, and

WHEREAS, Compliance by staff physicians with such a requirement would establish the precedence of Federal Bureaucratic control over the individual practice of medicine set the medicare patient apart from regular patients in their admission procedure for hospitalization and have the effect of forcing physicians to participate in medicare against their will and

WHEREAS, All hospitals and health insurance carriers including Illinois Blue Cross have always accepted an admitting diagnosis, adequate history and physical examination, and periodic progress notes as proper documentation for need of hospitalization and

WHEREAS, It is the desire of the members of the Illinois State Medical Society to continue to serve all patients in need of hospital medical care in the usual and customary manner regardless of whether such patients are medicare recipients, now therefore be it

RESOLVED, That the Illinois State Medical Society advises its members to continue to support ethical and equality medical care for all patients and to record same, and advises its members to refuse to sign special certification and recertification

forms or execute special statements of "Medical Necessity" for hospitalization of medicare recipients, and be it further

RESOLVED, That the Illinois State Medical Society condemns Illinois Blue Cross and the various hospitals that have required special certification and recertification forms or statements of "Medical Necessity" and asks that Illinois Blue Cross and the various hospitals accept the usual method of hospitalization for all patients and be it further

RESOLVED, That the Illinois State Medical Society instructs its delegates to the American Medical Association to present a similar resolution to the House of Delegates of the American Medical Association at its next session.

RESOLUTION NO. 67M-9

Introduced by: Henry-Stark County Medical Society

Subject: ISMS & AMA DUES

Referred to: Reference Committee on Finances & Budgets

WHEREAS, Spiraling inflation has reduced our purchasing power and

WHEREAS, We believe that enlarged budgets contribute to the inflationary trend and

WHEREAS, We should by precept and example review with diligence our own Illinois State Medical Society and AMA budget expansion, therefore be it

RESOLVED, That we do hereby protest the expanded budget with its resultant increased dues assessments; furthermore, that we make every effort to reduce the dues.

RESOLUTION NO. 67M-10

Introduced by: Henry-Stark County Medical Society

Subject: Association with Osteopathic Practitioners

Referred to: Reference Committee on Public Relations & Miscellaneous Business

WHEREAS, Osteopaths have repeatedly sought hospital staff privileges and

WHEREAS, Said osteopaths are licensed by the State of Illinois as physicians and surgeons and

WHEREAS, Said license is granted on the basis of having passed a "refresher course" examination and

WHEREAS, Said osteopaths have not had a recognized rotating internship and

WHEREAS, Said osteopaths are inadequately trained and

WHEREAS, Said osteopaths do not practice scientific medicine and

WHEREAS, Said osteopaths continue to practice cult medicine, therefore be it

RESOLVED, That despite the licensing by the State of Illinois it is unethical for a medical doctor to associate with a known cult osteopathic practitioner. Further that said osteopathic physicians be granted privileges subject to the same degree of skill and competence expected of an M.D. Further that

it is ethical to associate with an osteopath who, by scientific training and proven demonstrated skill, practices scientifically acceptable medicine and surgery.

RESOLUTION NO. 67M-11

Introduced by: DuPage County Medical Society

Subject: Ad Hoc Committee on Medical Education

Referred to: Reference Committee on Publications & Scientific Services

WHEREAS, The Ad Hoc Committee on Medical Education of the American Medical Association and the Millis Report reflect the current thinking of practicing physicians regarding medical education, and

WHEREAS, The Illinois State Medical Society has an established committee on medical education and an Ad Hoc Committee on medical education, therefore, be it

RESOLVED, That the members of the DuPage County Medical Society encourage the Illinois State Medical Society committees on medical education to review and implement the above reports, and therefore, be it further

RESOLVED, That the members of the DuPage County Medical Society encourage regular meetings of the Illinois State Medical Society Committee on Medical Education with a quarterly report to the Board of Trustees.

RESOLUTION NO. 67M-12

Introduced by: Will-Grundy County Medical Society

Subject: Acceleration of Reciprocity Licensure Process

Referred to: Reference Committee on Legislation

WHEREAS, Many communities in Illinois need physicians; and

WHEREAS, A physician duly licensed to practice medicine in another state of the United States has already passed a licensing examination; and

WHEREAS, The needed skills of a physician lie idle until he has received his Illinois State license by reciprocity; and

WHEREAS, Such aforementioned physicians are anxious to begin treating patients, now therefore be it

RESOLVED, That the Illinois State Medical Society urge the Department of Registration and Education to take every step possible to decrease the length of time between examination and issuing the license; and be it also

RESOLVED, That the Illinois State Medical Society urge the Department of Registration and Education to consider issuing a short term, temporary, once-in-a-lifetime license to those applicants who are graduates of a Class A United States medical school, who have been licensed in another state, and who qualify in all other respects for the Illinois reciprocity license examination.

RESOLUTION NO. 67M-13

Introduced by: Will-Grundy County Medical Society

Subject: Physicians on Administrative Boards of Hospitals

Referred to: Reference Committee on Publications & Scientific Services

WHEREAS, A hospital exists for purposes of medical treatment; and

WHEREAS, The governing body of the hospital establishes policies, enters into contracts and establishes building expansion programs; and

WHEREAS, Such actions of the governing body affect the medical wellbeing of the patient; and

WHEREAS, The decisions of the governing body affect the actions of the physicians on the medical staff, now therefore be it

RESOLVED, That the Illinois State Medical Society encourage the governing bodies of hospitals in the State of Illinois to include representation from the medical staff on such governing boards with full rights, privileges and responsibilities as all other board members.

RESOLUTION NO. 67M-14

Introduced by: Will-Grundy County Medical Society

Subject: Physical examinations under School Code of Illinois

Referred to: Reference Committee on Legislation & Public Affairs

WHEREAS, The School Code of Illinois, Section 27-8, states that medical and dental examinations for school youngsters be given one month prior to entrance into kindergarten or first grade, prior to fifth grade, and prior to entrance into high school; and

WHEREAS, This procedure can place a burden on examining physicians during the month of August of each year, and by virtue of the numbers of children to be examined, may result in an inferior type of examination; and

WHEREAS, There is no medical reason for this examination to be done one month prior to the entrance into the aforementioned grades; and

WHEREAS, Dental examinations may create similar problems, and therefore be it

RESOLVED, That the Illinois State Medical Society request the Illinois School Problems Commission of the State of Illinois Board of Education to request the legislature of the State of Illinois to amend School Code of Illinois, Section 27-8, to read:

Medical and dental examinations for school children are to be given either one month before entering kindergarten or first grade, fifth grade, and ninth grade, or within thirty days of

the birthdate of a child in the aforementioned grades.

RESOLUTION NO. 67M-15

Introduced by: Wayne County Medical Society

Subject: The Right of the Practicing Physician to Dispense Drugs and Appliances

Referred to: Reference Committee on Public Relations and Miscellaneous Business

WHEREAS, It has been customary for physicians practicing in Fairfield, Wayne County, Illinois, since the town was incorporated in 1820 to dispense drugs and appliances in the course of their practice, and

WHEREAS, An attempt was made during the 1966 meeting of the House of Delegates of the Illinois State Medical Society to declare such practice to be unethical and not in the best interest of the patient, and

WHEREAS, Mass production and packaging of drugs makes the compounding of prescriptions by pharmacists (in the local drug store) obsolete, and, also

WHEREAS, The local pharmacies also handle school supplies, gifts, hardware, china, appliances, short orders, and periodicals, and

WHEREAS, The great bulk of pharmaceutical services in the local pharmacy involve transferring pills from large bottles into small bottles or pouring liquid from large bottles into smaller bottles, and giving over the counter advice concerning symptomatic relief of headaches, colds, sore throats, coughs, sprains, burns, abrasions, constipation, dysuria, myalgia, lumbago, sunburn, diarrhea, and itch, and

WHEREAS, It is in the best interests of the patient that his physician be familiar with the medication that he is taking and with the effect that this medication has upon him, and

WHEREAS, This close supervision can best be obtained when the doctor actually examines and interviews the patient, and

WHEREAS, In the interest of conserving the patient's time and money, a one stop super-market type of operation is often most efficient; therefore be it

RESOLVED, That the Illinois State Medical Society at the 1967 meeting of the House of Delegates, reaffirm its traditional policy and position that a practicing physician may ethically dispense medications and other appliances so long as there is no exploitation of the patient, and that the practicing physician be encouraged to provide patients with the most economical and efficient total medical care possible, and that he be encouraged to experiment with new ways of organizing and delivering medical services, keeping in mind the best interests of the patient.

"Bettercare"

Program Summary

1967 ISMS Convention

Saturday, May 20

- 9:00 a.m. Finance & Executive Committees
Time Room 107
- 12:00 noon Board of Trustees Luncheon
Crystal Room
- 2:00 p.m. Board of Trustees Meeting
French Room 107

Sunday, May 21

- 10:00 a.m. Registration of Officers and Delegates
Parlors M-N-O
- 10:00 a.m. Reference Committee Chairmen
Orchid Room 106
- 12:30 p.m. District Meetings for Delegates
1st District, Dr. Clark, Trustee
Jade Room 103
2nd District
Holiday Room 105
4th District, Dr. Youngberg, Trustee
French Room 107
5th District, Dr. Trumpe, Trustee
Gold Room 114
6th District, Dr. Pfeiffenberger,
Trustee
Crystal Room
7th District, Dr. Goodyear, Trustee
Ruby Room 113
8th District, Dr. Schowengerdt,
Trustee
Parlor L
9th District, Dr. Wells, Trustee
Polo Room 102
10th District, Dr. Scrivner, Trustee
Gold Coast Room 111
11th District, Dr. O'Donnell, Trustee
Old Chicago Room 101
- 2:00 p.m. Credentials Committee, House of
Delegates
New Hall Mezzanine

- 3:00 p.m. House of Delegates
New Hall Mezzanine
- 5:30 p.m. Delegates Buffet
Louis XVI Room
- 6:00 p.m. Illinois Obstetrical and Gynecological
Society Board Dinner
- 7:00 p.m. Reference Committees:
Officers and Administration
Gold Room 114
Finances and Budget
Jade Room 103
Constitution and Bylaws
French Room 107
Economics and Insurance
Old Chicago Room 101
Legislation and Public Affairs
Ruby Room 113
Publications and Scientific Services
Orchid Room 106
Public Relations and Miscellaneous
Business
Crystal Room

Monday, May 22

- 8:00 a.m. Board of Trustees Breakfast
French Room 107
- 8:00 a.m. Illinois Surgical Society
Cook County Hospital
- 8:30 a.m. Illinois Obstetrical and Gynecological
Society
Crystal Room
- 8:30 a.m. Registration
Mezzanine
- 9:00 a.m. Occupational Health
Louis XVI Room
- 9:00 a.m. Reference Committee on Opinion
Survey
New Hall Mezzanine

- 9:00 a.m. Workshop on Medicare-Public Aid
Billing Problems
Old Chicago Room 101
- 10:00 a.m. Physicians Association of the Illinois
Mental Health Department
Gold Room 114
- 11:00 a.m. Official Opening of Exhibits
- Noon Illinois Obstetrical and Gynecological
Society Luncheon
Ruby Room 113
- 12:30 p.m. Impartial Medical Testimony
Luncheon
Old Chicago Room 101
- 1:30 p.m. Section on Surgery and Illinois Sur-
gical Society
New Hall Mezzanine
- 1:30 p.m. Section on Neurology and Psychiatry
Louis XVI Room
- 4:00 p.m. IMPAC Annual Meeting
Gold Room 114
- 5:00 p.m. Exhibits Close
- 6:00 p.m. Public Affairs Dinner and Camp
Lecture
Bal Tabarin
- 6:00 p.m. Past-Presidents' Dinner

Tuesday, May 23

- 8:00 a.m. Board of Trustees Breakfast
French Room 107
- 8:30 a.m. Registration Opens
Mezzanine
- 8:30 a.m. Section on Obstetrics and Gynecology
Ruby Room 113
- 8:30 a.m. Section on Allergy
Gold Room 114
- 9:00 a.m. Exhibits Open
- 9:00 a.m. Section on Internal Medicine
Old Chicago Room 101
- 10:30 a.m. Illinois Chapter, American College of
Chest Physicians
New Hall Mezzanine
- 12:00 p.m. Chest Physicians Luncheon
Old Chicago Room 101
- 12:30 p.m. Illinois Academy of Preventive
Medicine Luncheon
French Room 107
- 12:30 p.m. Fifty Year Club Luncheon
Bal Tabarin
- 1:00 p.m. Credentials Committee, House of
Delegates
New Hall Mezzanine
- 1:30 p.m. Section on Radiology
Crystal Room
- 1:30 p.m. Section on Physical Medicine and
Rehabilitation
Gold Room 114

- 2:00 p.m. Section on Public Health and
Preventive Medicine
Ruby Room 113
- 2:00 p.m. House of Delegates
New Hall Mezzanine
- 5:00 p.m. Exhibits Close
- 6:00 p.m. Illinois Society of Pathologists Dinner
Ruby Room 113
- 6:00 p.m. University of Illinois Alumni Dinner
Crystal Room and Louis XVI
- 6:30 p.m. Annual Banquet

Wednesday, May 24

- 8:00 a.m. Board of Trustees Breakfast
French Room 107
- 8:30 a.m. Registration Opens
Mezzanine
- 8:30 a.m. Section on Eye, Ear, Nose and Throat
Crystal Room
- 8:30 a.m. Section on Pathology
Gold Room 114
- 8:30 a.m. Section on Dermatology
New Hall Mezzanine
- 9:00 a.m. Exhibits Open
- 9:00 a.m. Section on Pediatrics
Louis XVI Room
- 11:00 a.m. Illinois Society of Internal Medicine
Jade Room 103
- 12:00 noon Medical Advisory Committee of the
Division of Vocational Rehabilitation
Luncheon
Rehabilitation Institute of Chicago
401 E. Ohio St., Chicago
- 12:15 p.m. Illinois Academy of General Practice
Luncheon
Old Chicago Room 101
- 12:30 p.m. Illinois Chapter, American Academy
of Pediatrics Luncheon
Gold Room 114
- 1:00 p.m. Credentials Committee, House of
Delegates
New Hall Mezzanine
- 1:00 p.m. Section on Anesthesiology
Louis XVI Room
- 1:30 p.m. Continuing Education Program in
Psychiatry for Physicians in Private
Practice, Chicago Medical School
Crystal Room
- 2:00 p.m. House of Delegates
New Hall Mezzanine
- 2:00 p.m. Symposium on Hemophilia, Mid-West
Chapter, National Hemophilia
Foundation
Ruby Room 113
- 5:00 p.m. Exhibits Close
- 6:00 p.m. Board of Trustees Dinner
Starlight Room

HOUSE OF DELEGATES MEETINGS

New Hall

Sunday, May 21	3 p.m.
Tuesday, May 23	2 p.m.
Wednesday, May 24	2 p.m.

REFERENCE COMMITTEE MEETINGS

Sunday, May 21	7 p.m.
Officers and Administration	Gold Room 114
Finances and Budget	Jade Room 103
Constitution and Bylaws	French Room 107
Economics and Insurance	Old Chicago Room 101
Legislation and Public Affairs	Ruby Room 113
Publications and Scientific Services	Orchid Room 106
Public Relations and Miscellaneous Business	Crystal Room
Monday, May 22	9 a.m.
Opinion Research Survey	New Hall—Mezzanine

BOARD OF TRUSTEES MEETINGS

SATURDAY, MAY 20	NOON	FRENCH ROOM 107
SATURDAY, MAY 20	2 P.M.	CRYSTAL ROOM
MONDAY, MAY 22	8 A.M.	FRENCH ROOM 107
TUESDAY, MAY 23	8 A.M.	FRENCH ROOM 107
WEDNESDAY, MAY 24	8 A.M.	FRENCH ROOM 107
WEDNESDAY, MAY 24	6 P.M.	STARLIGHT ROOM

Program is acceptable for six elective hours by the American Academy of General Practice.

The Wednesday program on the "Medical Problems of the Aged and Simple Minded" is also acceptable for an additional three hours of elective credit.

CALLS WILL REACH YOU EASILY AT '67 CONVENTION

Doctor, please inform your staff that while you are attending the ISMS Convention you may be reached through the Physician's Message Center from 2:00 p.m., to 5:00 p.m. Sunday, and from 9:00 a.m. to 5:00 p.m., Monday, Tuesday and Wednesday. Here is the number to remember:

AC 312-782-2151

This is a direct connection which does not go through the hotel switchboard.

Convention Program by Days

ILLINOIS SURGICAL SOCIETY

Monday, May 22 Surgical Amphitheatre
Cook County Hospital

Chairman of Surgical Symposium:
J. C. Thomas Rogers, M.D.

8:00-10:00 a.m. Moderator:
Charles B. Puestow, M.D.

"Surgery of Pancreas"

Robert J. Freeark, M.D., Surgeon
Discussion: W. James Gillesby, M.D., John
W. Fritch, M.D.

10:00-11:00 a.m. Moderator:
John T. Reynolds, M.D.

"Obstructive Jaundice"

Discussion: Earl O. Latimer, M.D., Edward
Paloyan, M.D., William H. Requarth, M.D.

11:00 a.m.-12:00 p.m. Hektoen Institute

"Postoperative Surgical Complications"

James D. Hardy, M.D., Professor and Chair-
man of Department of Surgery, University
of Mississippi, Jackson, Mississippi

8:00-10:30 a.m. Opr. Room "A"
Moderator: E. Lee Strohl, M.D.

"Surgical Management of Massive Hemorrhage of Stomach"

Peter S. Rosi, M.D., Surgeon

"Gastric Operations"

Rene Menguy, M.D.

"Exploratory Gastrotomy for Massive Upper Gastrointestinal Hemorrhage"

Manuel E. Lichtenstein, M.D.

8:00-10:30 a.m. Opr. Room "B"

Moderator: Foster L. McMillan, M.D.

"Management of Diverticular Disease of Colon"

Frederic dePeyster, M.D., Surgeon

"Management of Ulcerative Colitis"

T. Howard Clarke, M.D., Charles D. Branch,
M.D., Everett P. Coleman, M.D.

8:00-10:30 a.m.

Opr. Room "C"

Moderator: Carl B. Davis, M.D.

"Cardiac Valve Replacement"

Milton Weinberg, M.D.

Discussion: William E. Neville, M.D., John

L. Keeley, M.D., John C. Cooley, M.D.

8:00-10:30 a.m.

Opr. Room "D"

Moderator: Kenneth H. Schnepf, M.D.

"Operations for Breast Tumors"

Robert L. Schmitz, M.D., Surgeon

"Palliative Treatment of Advanced Carcinoma of Breast"

Louis P. River, M.D.

"Place of Oophorectomy in Cancer of the Breast"

George E. Block, M.D., Robert J. Patton, M.D.

8:00-10:30 a.m.

Opr. Room "E"

Moderator: Arkell M. Vaughn, M.D.

"Practical Approach to Vaginal Hysterectomy"

Walter J. Reich, M.D., Surgeon

"Office Gynecology"

Mitchell Nechtow, M.D.

Discussion: William Johnson, M.D.

MEMBERS OF THE MEDICAL PROFES-
SION ARE INVITED TO ALL SESSIONS
NO REGISTRATION FEE

COOK COUNTY HOSPITAL TRAUMA CENTER

"Tour of Cook County Hospital Trauma Center"

"Management of Shock Due to Acute Trauma"
William Shoemaker, M.D.

"Management of Shock Due to Hemorrhage & Burn Injuries"

John A. Boswick, Jr., M.D.

ILLINOIS OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Monday, May 22

Crystal Room

8:30 a.m. Business Meeting, Paul Raber, M.D., President presiding.

8:45 a.m. Case reports from the floor

9:00 a.m. "Obstetrical Emergencies—A Panel Discussion"

Moderator: Denis Cavanagh, M.D., Professor and Chairman, Gynecology and Obstetrics, St. Louis University, St. Louis, Mo.

Panelists:

"Septic Shock"

Dr. Cavanagh

"Obstetrical Hemorrhage"

Thomas Wilson, M.D., Chief, Obstetrics and Gynecology, Carle Clinic, Urbana

"Anesthesia Accidents"

Bradley E. Smith, M.D., Associate Professor, Anesthesiology, University of Miami and Jackson Memorial Hospital, Miami, Fla.

12:00 noon Luncheon

Ruby Room 113

1:00 p.m. "Sex Education — Part Two: What We Can Do in Our Communities" Crystal Room

Moderator: Hubert Allen, M.D., Clinical Faculty, Washington University, St. Louis, Mo.; Chief, Obstetrics and Gynecology, St. Joseph's Hospital, Alton.

Panelists:

John W. Huffman, M.D., Professor, Obstetrics and Gynecology, Northwestern University; Attending, Passavant Hospital; Attending and Chief of Department, Children's Memorial Hospital, Chicago.

R. Clay Burchell, M.D., Associate Professor, Obstetrics and Gynecology, University of Illinois Medical Center, Chicago.

James P. Semmens, Captain, MC, USN, Chief of Obstetrics and Gynecology, U.S. Naval Hospital, Oakland, Calif.

Lucius F. Cervantes, S. J., Ph.D., Professor, Sociology, St. Louis University, Research Assistant to the Mayor of St. Louis, Mo.

Don Oakes, M.A., Director of Secondary Instruction, Hayward Unified School District, Hayward, Calif.

Discussion from the floor.

OCCUPATIONAL HEALTH

Monday, May 22

Louis XVI Room

9:00 a.m.

PHYSICIANS ASSOCIATION OF ILLINOIS MENTAL HEALTH DEPARTMENT

Monday, May 22

Gold Room 114

Program Chairman: Werner Tuteur, M.D.

10:00 a.m. "The Community and Psychiatry?"

Jack Mabley, Assistant Managing Editor, Chicago's American

IMPARTIAL MEDICAL TESTIMONY

Monday, May 22

Old Chicago Room 101

12:30-2:00 p.m. Luncheon

SECTION ON SURGERY AND ILLINOIS SURGICAL SOCIETY

Monday, May 22

New Hall-Mezzanine

Chairmen: Lorin D. Whitaker, M.D., Peoria
Richard Lawler, M.D., Chicago

1:30 p.m. Panel: "Management of Colon Pathology"

Moderator: R. Kennedy Gilchrist, M.D., Professor of Surgery, University of Illinois College of Medicine

Panelists: Peter A. Rosi, M.D., Professor of Surgery, Northwestern University School of Medicine

Orvar Swenson, M.D., Professor of Surgery, Northwestern University School of Medicine

George E. Block, M.D., Professor of Surgery, University of Chicago School of Medicine

2:30-3:30 p.m. "Management of Surgical Complications—Circulatory—Respiratory—Abdominal"

James D. Hardy, M.D., Professor and Chairman, Department of Surgery, University of Mississippi

3:30-4:30 p.m. Panel: "Cardiovascular Surgery"
Moderator: William S. Dye, M.D., Associate Professor of Surgery, University of Illinois College of Medicine

"Carotid Endarterectomy"

Arthur de Boer, M.D., Assistant Professor of Surgery, Northwestern University School of Medicine

"Management of Arterial Injuries"

Robert J. Freeark, M.D., Associate Professor of Surgery, Northwestern University School of Medicine

"Iliofemoral Endarterectomy"

Otto H. Trippel, M.D., Assistant Professor of Surgery, Northwestern University School of Medicine

SECTION ON NEUROLOGY AND PSYCHIATRY

Monday, May 22

Louis XVI Room

Chairman: Harold E. Himwich, M.D., Galesburg

Psychiatry: Treatment of Patients with Various Aspects of Anxiety and/or Mild Depression

1:00 p.m. "The Use of Minor Tranquilizers in the Treatment of Clinical Manifestations of Anxiety"

Antioco R. Barron, M.D., Chief of Service, Institute Service, Illinois State Psychiatric Institute, Chicago

1:30 p.m. "Doctors, Patients and Tranquilizers: Recent Developments"

Paul Lowinger, M.D., Chief of Outpatient Clinic, Lafayette Clinic; Associate Professor of Psychiatry, Wayne State University, Detroit, Mich.

2:15 p.m. Exhibit Break

Neurology: Treatment of Patients with Neurological Complications

2:45 p.m. "Hypersensitive Carotid Sinus as a Cause of Impairment of Consciousness; Its Recognition and Treatment"

George M. Cummins, Jr., M.D., Assistant Professor of Medicine, Northwestern University School of Medicine

H. R. Oberhill, M.D., Associate Professor of Surgery, Northwestern University School of Medicine

Paul Bucy, M.D., Professor of Surgery, Northwestern University School of Medicine

3:15 p.m. "Some Practical Points in the Handling of the Head Injured Patient"

Joseph P. Evans, M.D., Professor and Director of the Division of Neurological Surgery, University of Chicago Hospitals

3:45 p.m. "Modern Technics in the Management of Pain"

John F. Mullan, M.D., Professor of Neurological Surgery, University of Chicago

IMPAC ANNUAL MEETING

Monday, May 22

Gold Room 114

4:00 p.m.

PUBLIC AFFAIRS DINNER CAMP MEMORIAL LECTURE

Monday, May 22

Bal Tabarin

6:00 p.m. Reception and Dinner

8:00 p.m. Camp Memorial Lecture

SECTION ON ALLERGY

Tuesday, May 23

Gold Room 114

Chairman: Arnold A. Gutman, M.D., Chicago

8:30 a.m. "Meteorology and Misery: A Consideration of How Weather Affects Allergic Symptoms"

Donald B. Frankel, M.D., Chicago

9:00 a.m. "In-Vitro Model Systems for Delayed Hypersensitivity: Problems and Prospects"

Philip Y. Paterson, M.D., Professor of Medicine and Chief, Section of Infectious Diseases and Hypersensitivity, Northwestern University Medical School

9:30 a.m. "Nasal Physiology in the Allergic and Non-Allergic Nose"

Paul Seeborn, M.D., Professor of Medicine, University of Iowa College of Medicine, Iowa City, Iowa

10:30 a.m. Exhibit Break

11:00 a.m. "Fun with Skin Tests"

Panelists:

Ray F. Beers, Jr., M.D., Assistant Clinical Professor of Medicine, University of Illinois College of Medicine

Milda Budrys, M.D., Clinical Instructor of Medicine, University of Illinois College of Medicine

Max Samter, M.D., Professor of Medicine, University of Illinois College of Medicine

Gregory O. Zeman, M.D., Clinical Instructor of Medicine, University of Illinois College of Medicine

11:30 a.m. "Urticaria: A Symptom of Widely Divergent Allergic, Non-Allergic, Benign, and Fatal Disorders"

John S. Thompson, M.D., Associate Professor of Medicine, University of Chicago School of Medicine

SECTION ON OBSTETRICS AND GYNECOLOGY

Tuesday, May 23

Ruby Room 113

Chairman: William W. Curtis, M.D., Springfield

8:30 a.m. Business Meeting

9:00 a.m. "Varicose Veins and Pregnancy"

Jack C. Cooley, M.D., Department of Cardiovascular and Thoracic Surgery, Carle Clinic, Urbana

9:20 a.m. "Delayed Postpartum Hemorrhage"

Thomas W. Mc Elin, M.D., Chairman, Department of Obstetrics and Gynecology, Evanston Hospital, Evanston

9:45 a.m. "Office Gynecology"

Denis Cavanagh, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, St. Louis University, St. Louis, Mo.

10:15 a.m. Exhibit Break

10:45 a.m. "The Partnership of the Department of Public Health, Medicine, and Hospitals in the Care of Obstetrical and Gynecological Patients in Hospitals"

Franklin D. Yoder, M.D., Director, Illinois Department of Public Health

11:00 a.m. "Menopause? Never!" Panel Discussion

Moderator: Edwin DeCosta, M.D., Associate Professor, Obstetrics and Gynecology, Northwestern University

Panelists:

M. Edward Davis, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, University of Chicago (retired).
John R. Wolff, M.D., Associate Professor, Obstetrics and Gynecology, University of Illinois

SECTION ON INTERNAL MEDICINE

Tuesday, May 23

Old Chicago Room 101

Chairman: Angelo P. Creticos, M.D., Chicago

9:00 a.m. Moderator:

Herbert Bessinger, M.D., Clinical Assistant Professor of Medicine, University of Illinois; Director of Medical Education, Weiss Memorial Hospital, Chicago

"The Acute Cardiac Care and Intensive Care Units"

Panelists:

Rolph Gunnar, M.D., Associate Professor of Medicine, University of Illinois; Director, Illinois Service, Cook County Hospital
Sheldon Slodski, M.D., Associate Professor of Medicine, Chicago Medical School; Chief of Heart Station, Mt. Sinai Hospital, Chicago

Question and answer period.

ILLINOIS CHAPTER—AMERICAN COLLEGE OF CHEST PHYSICIANS

Tuesday, May 23

New Hall—Mezzanine

10:00 a.m. Registration

10:30 a.m. Scientific Session

"Respiratory Failure in Myocardial Infarction"

Reuben M. Cherniack, Professor of Medicine, University of Manitoba; Director, Respiratory Division, The Clinical Investigation Unit, Winnipeg General Hospital, Winnipeg, Canada

11:30 a.m. Discussion

12:00 noon Luncheon

Business Meeting and election of Officers, Illinois Chapter

PUBLIC HEALTH LUNCHEON

Tuesday, May 23

French Room 107

12:00 p.m. Luncheon—Illinois Academy of Preventive Medicine jointly with Section on Preventive Medicine and Public Health, Illinois Chapter—American Association of Public Health Physicians, and Illinois Association of Medical Health Officers

Open to all physicians

"Teaching Community Medicine in Kentucky"

Hugh S. Fulmer, M.D., Professor of Community Medicine, University of Kentucky, Lexington, Ky.

SECTION ON RADIOLOGY

Tuesday, May 23 **Crystal Room**
Chairman: J. Homer Goodlad, M. D., Peoria

1:30 p.m. "Carcinoma of the Lung"

Walter Whitehouse, M.D., Chief, Department of Radiology, University of Michigan, Ann Arbor, Mich.

2:30 p.m. Exhibit Break

3:00 p.m. Film Reading Panel

John Fennessy, M.D., Assistant Professor of Radiology, University of Chicago
Myron Green, M.D., MacNeal Memorial Hospital, Berwyn
B. Jay Hill, M.D., Presbyterian-St. Luke's Hospital, Chicago
Philip D. Brooks, M.D., Rockford Memorial Hospital, Rockford

4:30 p.m. Business Meeting, Illinois Chapter, American College of Radiology

5:00 p.m. Reception **Jade Room 103**

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

Tuesday, May 23 **Gold Room 114**
Chairman: W. T. Liberson, M.D., Hines

1:30 p.m. "Neck and Arm Pain"

Rene Cailliet, M.D., Associate Clinical Professor, University of Southern California, School of Medicine, Department of Physical Medicine and Rehabilitation; Department Head, Physical Medicine, Kaiser Foundation Hospitals, Southern California; Chief, Physical Medicine, South California Permanent Medical Group, Los Angeles
Theodore Cole, M.D., Department of Physical Medicine and Rehabilitation, University of Minnesota, Minneapolis
Discussion

SECTION ON PREVENTIVE MEDICINE AND PUBLIC HEALTH

Tuesday, May 23 **Ruby Room 113**
Chairman: Fred Long, M.D., Peoria

2:00 p.m. "The Teaching of Community Health in Medical Schools"

Moderator: Franklin D. Yoder, M.D.; President, Illinois Academy of Preventive Medicine

Panelists:

Hugh S. Fulmer, M.D.; Professor of Community Medicine, University of Kentucky Medical School

Edward S. Peterson, M.D., Assistant Dean Northwestern University Medical School

Albert Dorfman, M.D., Chairman, Department of Pediatrics and Professor of Pediatrics and Biochemistry, University of Chicago, School of Medicine

Walter S. Wood, M.D., Chairman, Department of Preventive Medicine and Public Health, Stritch School of Medicine, Loyola University

Herbert K. Abrams, M.D., Professor of Preventive Medicine and Community Health, Chicago Medical School

Adrian Ostfeld, M.D., Professor and Head, Department of Preventive Medicine, University of Illinois College of Medicine

SECTION ON EYE, EAR, NOSE AND THROAT

Wednesday, May 24 **Crystal Room**
Chairman: Roland I. Pritikin, M.D., Rockford

8:30 a.m. "The Future of Deafness Cures"

S. Bruce Mer, M.D., E.N.T. Clinic Staff, University of Illinois

9:00 a.m. "The Etiology of Poor Vision in Infants"

M. Alex Krill, M.D., Associate Professor of Ophthalmology, University of Chicago

9:30 a.m. "Survey of Cryo-ophthalmology"

John G. Bellows, M.D., Ph.D., Professor of Ophthalmology, Northwestern University

10:00 a.m. "The Pathology of Complications of Ocular Surgery"

S. Lawrence Samuels, M.D., Ophthalmological Pathologist, Manhattan Eye and Ear Hospital, and the New York Eye and Ear Infirmary

10:30 a.m. "Preventive Ophthalmology: Glaucoma, Myopia, Amblyopia"

Abraham Schlossman, M.D., Clinical Associate Professor of Ophthalmology, State University of New York Downstate Medical Center; Attending Surgeon in Ophthalmology, Manhattan Eye and Ear Hospital

11:00 a.m. "Disputed Entities in Corticosteroid Therapy"

Dan M. Gordon, M.D., Professor of Ophthalmology, Cornell University

SECTION ON PATHOLOGY

Wednesday, May 24 Gold Room 114
Chairman: Grover L. Seitzinger, M.D., Dan-
ville

8:30 a.m. "Antibiotic Sensitivity Testing"
Harry B. Harding, M.D., Evanston

9:50 a.m. Exhibit Break

10:35 a.m. "Pathological Lesions Secondary to
Antibiotic Therapy"
David Spain, M.D., Brookdale Hospital,
Brooklyn, N. Y.

SECTION ON DERMATOLOGY

Wednesday, May 24 New Hall—Mezzanine
Chairman: Sidney Barsky, M.D., Oak Brook

9:00 a.m. "Diabetic Dermadromes"
Theodore Cornbleet, M.D., Clinical Profes-
sor of Dermatology, University of Illinois

9:30 a.m. "Atypical Lesions Found in Common
Mycological Infections"
Irene Neuhauser, M.D., Clinical Associate
Professor of Dermatology, University of Il-
linois

10:00 a.m. Exhibit Break

10:45 a.m. "The Fearsome Foursome of Blister-
ing Dermatoses"
Frederick J. Szymanski, M.D., Clinical Pro-
fessor of Dermatology, University of Illinois

11:15 a.m. "Recent Advances in the Diagnosis
and Treatment of Syphilis"
Louise E. Taves, M.D., Clinical Associate Pro-
fessor of Dermatology, University of Illinois

11:45 a.m. Question and answer period

SECTION ON PEDIATRICS

Wednesday, May 24 Louis XVI Room
Co-Chairmen: James Conner, M. D., Hinsdale
Ira M. Rosenthal, M.D., Chicago

9:00 a.m. "Intravascular Clotting: Recognition
and Treatment with Specific Relation to Men-
ingococcemia"
Charles Abildgaard, M.D., Associate Professor
of Pediatrics, University of Illinois
"Intussusception"
Mark M. Ravitch, M.D., Professor of Pediatric
Surgery, University of Chicago

"The Pathogenesis and Prevention of Rh Im-
munization"

Alvin Zipursky, M.D., Professor and Chair-
man of Pediatrics, McMaster University,
Hamilton, Ontario

*Dr. Zipursky's participation is sponsored by
a grant from the Pet Milk Co.*

"Current Studies on Group A—Streptococcal
Immunization"

Eugene N. Fox, Ph.D., Associate Professor, La
Rabida University of Chicago Institute

*Dr. Fox's participation is sponsored by a
grant from Mead Johnson Laboratories.*

ILLINOIS SOCIETY OF INTERNAL MEDICINE

Wednesday, May 24 Jade Room 103
11:00-12:00 noon Reception

Noon Luncheon
1:00 p.m. Annual Meeting

Speakers: James J. Feffer, M.D, President-
Elect, American Society of Internal Medi-
cine

Philip G. Thomsen, M.D., Trustee, Illinois
State Medical Society and Chairman, Com-
mittee on Usual and Customary Fees.

SECTION ON ANESTHESIOLOGY

Wednesday, May 24 Louis XVI Room
Chairman: John T. Nelson, M.D., Elgin

1:00 p.m. "Experimental Atelectasis During Ar-
tificial Ventilation"

Christian Rattenborg, M.D., Associate Pro-
fessor of Anesthesiology, University of Chi-
cago

1:45 p.m. "Treatment of Hiccups by Pharyn-
geal Stimulation in Anesthetized and Con-
scious Subjects"

M. R. Salem, M.D., Assistant Professor of
Anesthesiology, University of Chicago

2:30 p.m. Exhibit Break

3:00 p.m. "The Anaesthetist Looks at Kidney
Transplantation. A Review of Three Years"

Gordon M. Wyant, M.D., Professor of Anaes-
thesia, University of Saskatchewan

*Dr. Wyant's participation is made possible
in part by a grant from Ohio Chemical &
Surgical Equipment Co.*

4:00 p.m. "The Anaesthetist and Dental Anesthesia"

W. N. Rollanson, M.B., Ch.B., F.F.A., R.C.S.;
Clinical Senior Lecturer, Anaesthetics, University of Aberdeen; Visiting Professor, Northwestern University School of Medicine

DIVISION OF VOCATIONAL REHABILITATION LUNCHEON AND TOUR

Wednesday, May 24

Rehabilitation Institute of Chicago
401 E. Ohio St.

1:30 p.m.

Henry Betts, M.D., Medical Director, Rehabilitation Institute of Chicago
Tour of Rehabilitation Center
Discussion Period

CONTINUING EDUCATION PROGRAM IN PSYCHIATRY FOR PHYSICIANS IN PRIVATE PRACTICE

(Sponsored by the Department of Psychiatry and Neurology of The Chicago Medical School: Chairman and Professor: H. H. Garner, M.D.)

MEDICAL PROBLEMS OF THE AGED AND OF THE SIMPLE-MINDED

Wednesday, May 24

Crystal Room

Chairman: John Cowen, M.D., Clinical Associate Professor of Psychiatry, Chicago Medical School

1:30 p.m. Introductory Remarks: H. H. Garner, M.D.

"Objectives of the Chicago Medical School Continuing Education Program"

PSYCHIATRIC PROBLEMS IN THE AGED

1:50 p.m. "Clinical Features and Management of the Commoner Mental Disorders in Old People"

Jack Weinberg, M.D.

2:15 p.m. Open Discussion:

Moderator: LeRoy Levitt, M.D.

2:40 p.m. Exhibit Break

THE SIMPLE-MINDED PATIENT

Moderator: Herbert J. Grossman, M.D.

2:55 p.m. Introduction: John Cowen, M.D.

3:00 p.m. "Recognition of the Problem"
"Social Placement of the Subnormal"

Harvey D. Zuckerberg, B. A.

3:25 p.m. "Etiology and Office Diagnosis"

James Crawford, M.D.

3:40 p.m. "Recognition and Management of the Retarded Epileptic"

Sherman Kaplitz, M.D.

3:55 p.m. "The Law and the Retarded Patient"

Robert Reifman, M.D.

4:10 p.m. Questions

4:30 p.m. Summing up: Herbert J. Grossman, M.D.

SYMPOSIUM ON HEMOPHILIA

Wednesday, May 24

Ruby Room 113

"Hemophilia, A Not Uncommon Entity"

Symposium presented under the sponsorship of the Midwest Chapter, National Hemophilia Foundation

2:00 p.m. "Introduction to the General Topic of Hemophilia: Clinical Picture"

S. Frederick Rabiner, M.D., Director of Clinical Hematology, Michael Reese Hospital and Medical Center

2:20 p.m. "Laboratory Diagnosis of Hemophilia"

J. N. Shanberge, M.D., Director of Hematology Laboratories and Blood Bank Evans-ton Hospital

2:40 p.m. "Principles of Treatment with Plasma and Factor VIII Concentrates"

Charles Abildgaard, M.D., Associate Professor, Department of Pediatrics, University of Illinois Medical Center

3:00 p.m. Exhibit Break

3:45 p.m. "Orthopedic Problems and Other Surgical Aspects of Hemophilia"

Melvin Post, M.D., Attending Orthopedist, Michael Reese Hospital, Medical Center

4:00 p.m. "Nursing Care"

Miss Gladys Morris, R.N., Sarah Morris Hospital, Michael Reese Hospital

4:15 p.m. "Educational Facilities for the Hemophilic"

Miss Evelyn Albert, Principal, Spalding School, Chicago

4:30 p.m. Question and answer period

Scientific Exhibits

S-1

Title: Asymptomatic Bacteriuria of Pregnancy

Exhibitors: Morten B. Andelman and Jack Zackler

Institution: Chicago Board of Health, Chicago

Description: Charts and graphs to demonstrate the incidence of asymptomatic bacteriuria in pregnancy and the result of treatment with a new urinary antiseptic, methenamine hippurate are displayed. In addition, this exhibit demonstrates the reduction of premature rate when this disease of pregnancy is discovered early and treated until term.

S-2

Title: Significance of Splenic Concentration of Radioactive Gold in Liver Scans

Exhibitors: Hyo H. Byun, Marion F. Magalotti, Raymond J. Des Rosier, Paul B. Szanto, Fernando Villa, Frederick Steigmann and Iltifat A. Alavi

Institution: Departments of Radiation Therapy & Nuclear Medicine, Pathology and Gastroenterology of the Cook County Hospital, Chicago

Description: This exhibit attempts to demonstrate the significance of splenic concentration of radioactive colloidal gold in liver scans. One hundred and three cases of varying degree of splenic concentration found in over 600 liver scans performed at Cook County Hospital in the last year and a half are correlated with clinical, biochemical data, laparoscopy and liver biopsy. We conclude that the common etiology is due to cirrhosis of liver which is helpful in establishing the clinical diagnosis and clinical management.

S-3

Title: The Womanly Art of Breast Feeding

Exhibitors: Robert Mendelsohn, Gregory White and Herbert Ratner

Institution: La Leche League International, Franklin Park

Description: This is an exhibit prepared by a committee for La Leche League International through consultations with its members and medical advisory board. Information on breast feeding has been gathered over a ten year period through communication with mothers throughout the country and the world and through constant consultation with our Medical Advisors who have taken a special interest in this subject. The main question was . . . why were so many women who had true desire and apparent good health failing to succeed at breast feeding their babies? Not only did we find out why women were failing at breast feeding even when they really wanted to, but we found out many other facts, medical and non-medical which concern themselves directly with breast feeding. This exhibit illustrates these findings.

S-4

Title: Glaucoma Screening in Physicians' Offices

Exhibitors: James E. McDonald, Marilyn T. Miller and Mary M. Dahl

Institutions: University of Illinois College of Medicine and Illinois Society for the Prevention of Blindness, Chicago

Description: The exhibit details the importance of the tonometer as a screening instrument for glaucoma detection in the offices of general practitioners

and internists. An enlarged working model of the tonometer demonstrates principles involved. A series of photos and pamphlets show the technique. Results to be expected from such activity in the offices of private physicians are given.

S-5

Title: Kidney Size Variation During Arteriography in Hypertensives

Exhibitors: Miriam Liberson and John W. Coleman

Institution: Veteran's Administration West Side Hospital, Chicago

Description: The kidney length was measured in rapid serial films of retrograde femoral aortograms in 89 male hypertensive patients. In 83 out of 89 cases, fluctuations in length were observed. These fluctuations are unilateral or bilateral varying in amplitude from 0.2 to 1.1 cm. They are not necessarily of the same direction. The difference in length between the two kidneys may vary by as much as 1 cm. or more within 8 seconds (duration of observation for each case). None of the clinical diagnostic groups revealed a characteristic pattern as to amplitude or direction of fluctuation. Evaluation of kidney size on serial examinations may be of critical clinical significance. From this practical point of view our study indicates that the usual measurements of the kidney length on only one of the serial films may be unreliable and possibly misleading.

S-6

Title: Clinical Application of Mammography

Exhibitor: Franklin S. Alcorn

Institution: Presbyterian-St. Luke's Hospital, Chicago

Description: Carcinoma of the breast is the most prevalent malignant neoplasm in adult women today. The mortality and morbidity rate has increased over the past decades despite all efforts directed toward early diagnosis and treatment. Regardless

of one's opinion concerning biologic determinism, early radical surgery is still felt to be the best definitive treatment. It is one of the main purposes of mammography to aid in the earlier detection and clinical management of malignant neoplasm of the breast. This exhibit purports to demonstrate a number of clinical situations in which mammography assists in the relatively early detection of malignant neoplasm of the breast. It also demonstrates the differences between benign and malignant disease and, therefore, offers a useful ancillary diagnostic device to the clinician in the management of breast problems.

S-7

Title: Triggering Mechanisms of Malignant Changes in the Oral Mucosa

Exhibitors: Orion H. Stuteville, Robert M. Vanecko and William J. Hagstrom, Jr.

Institution: Department of Plastic Surgery, Cook County Hospital, Chicago

Description: The exhibit depicts various aspects of irritating factors in the causation of carcinoma of the oral mucosa. Various colored pictures show cigarettes, cigars, snuff and chewing tobacco with resultant carcinomas of the adjacent oral mucosa.

S-8

Title: Histopathology of the Inner Ear in Congenital Deafness

Exhibitors: John R. Lindsay and David D. Beal

Institution: University of Chicago, Chicago

Description: Histopathology of the inner ear in congenital deafness includes both genetically related deafness and deafness acquired in-utero. The genetically related cases include trisomy 13 and 15, trisomy 18, and the Mondini type. The types acquired in-utero include rubella and drug intoxication. Also included are cases of deaf mutism due to bacterial meningogenic labyrinthitis. For purposes of comparison, examples are shown of inner ear

pathology as found in hereditary deafness of Dalmation dogs, white cats and walzing guinea pigs.

S-9

Title: Why Risk Heart Attack?
Exhibitor: Louis deBoer
Institution: The Chicago Heart Association, Chicago
Description: The exhibit lists and describes six factors of heart attack risks.

S-10

Title: Aortic Homografts in the Repair of Diaphragmatic Hernias
Exhibitors: Samuel J. Fogelson and Peter A. Rosi
Institution: Northwestern University Medical School, Chicago
Description: The exhibit consists of 18 illuminated transparencies, the first of which is a high power micro photo of human aorta removed four years after insertion in the abdominal wall where it had been utilized as an adjunct in hernia repair. It shows an elastica which is intact without inflammatory reaction, calcification or fragmentation. The second is a colored photograph of a human eye from a patient with scleramalacia perforans, four years after the cornea was reinforced by aortic graft, showing some capillary invasion and intact aorta. The next six transparencies show stages of repair, emphasizing essentially the fact that approximated crus of the diaphragm are reinforced by homograft, thus taking tension off the suture line and forming a solid elastic membrane to which the posterior aspect of the phreno-esophageal ligament is anchored. The acute esophageal-gastric angle is also restored and the anterior portion of the phreno-esophageal ligament is then sutured to the under surface of the diaphragm. Finally, the cardia of the stomach is also sutured to the diaphragm. Appropriate legends accompany each transparency.

S-11

Title: Food and Gastrointestinal Disorders
Exhibitors: Jeanne Wallace, Mary Jane Kibler and Eleanor Powell
Institution: The American Medical Association, Chicago
Description: This exhibit asks the question "How rational are dietary practices?", and calls for objective research that includes controls, eliminates prejudice and psychic influence and makes due allowance for chance variation in diet therapy.

S-12

Title: Congenital Deformities of the Chest Wall
Exhibitor: Mark M. Ravich
Institution: University of Chicago, Wyler Children's Hospital, Chicago
Description: Transparencies in groups of four relating to a single patient are shown with appropriate legends. Also shown are large operative drawings of the principal procedures tied in with these particular patients.

S-13

Title: New Approaches for Corrective Hearing Loss in Children
Exhibitor: Emanuel M. Herzon
Institution: Sherman Hospital, Elgin
Description: The results of correction of hearing loss in children were analyzed with 122 cases and indicated the advantages of the method used with eliminated paracentesis and plastic tube inserts, etc. Results were obtained without significant recurrences and by simple treatments and medication as illustrated. Special X-rays used for measuring the velo-pharyngeal airway also indicated the need for sinus displacement treatment as shown. Cytological examination guided the medication and audiometric determinations were done by photo-audio conditioning technique also illustrated.

S-14

Title: Medical Aspects of Family Planning

Exhibitors: Frederick H. Falls and Charlotte S. Holt

Institution: Illinois State Department of Public Health, Springfield

Description: This is one of the most important problems facing the people of this and other countries today. Little is known about the fundamental factors involved in these problems by the average well educated citizens of all countries. This exhibit is presented to fill in gaps in the common knowledge of high school graduates who may seek advice from the general practitioners to assist him in his attempt to furnish through visual education the fundamental knowledge on the subjects of Sterility, Population Control, Physiology of Conception, Contraception and Abortion. No advice or suggestions are offered. Only facts are made available for use in coming to decisions by people of varied educations, religions and culture.

S-15

Title: Differential Diagnosis of Syphilis

Exhibitors: Samuel L. Andelman, Willard B. Fessenden, Jr., T. R. Thiebaut

Institution: Chicago Board of Health, V. D. Control Section, Chicago

Description: This exhibit utilizes a dimensional photographic process to depict the lesions of infectious syphilis in conjunction with other dermatological lesions. The objective of this exhibit is to raise the physician's index of suspicion and to alert him to the severity of the syphilis problem in Chicago.

S-16

Title: Conjoined Twins: Xipho-Omphalopagus (Siamese Twins), Cranio-pagus, Pygopagus

Exhibitor: George B. Callahan

Institutions: Victory Memorial and St. Therese Hospitals, Waukegan, and Women's Hospital, Bangkok

Description: Sixteen sets of conjoined twins are shown. Survivals include: four sets unseparated including Eng and Chang and 5th generations' of descendants, and twelve separated sets with common livers, brain tissue, pelvic organs and/or bones severed. Eighteen of twenty-four individuals survived. Pictures and charts reveal history, care and recommended procedures; prenatal diagnosis, contrast x-rays, cesarean section deliveries, surgical separation beyond twenty months. Collaborators: Doctors Nitya and Sem, Bangkok; Dragstedt, Sugar, Greenley, Voris, Freeman, Perlstein, Oberhelman and Sadove, Chicago; Ochsner, New Orleans; Koop, Philadelphia; Carrai, Florence; Solerio, Turin; Gedda, Rome; Rottgen, Bonn; Duhamel, Paris and Durr, Rock Island.

S-17

Title: Chronic Respiratory Diseases as a Cause of Disability

Exhibitors: Edward G. Ference, Harry Grant, J. W. Hill, Alfred Slicer

Institution: Federal Disability Program, State of Illinois, Division of Vocational Rehabilitation, Springfield

Description: The exhibit describes the kinds of clinical findings needed by the social security disability program to assess remaining capacity for work and make determination of disability on patients with respiratory impairments. It further describes disability program experience in evaluating claims filed by persons with chronic respiratory impairments.

S-18

Title: Gastrocamera—Photography

Exhibitor: Olimpo Galindo

Institution: Illinois Masonic Hospital, Chicago

Description: Exhibit consists of three panels: left shows photograph illustrating

simplicity of the use of the gastro-camera, listing advantages. Central panel has drawings of the stomach showing camera's flexibility, curving and moving up to the gastric vault to view the "blind areas" of conventional gastroscopy. Lower part shows color photographs of lesions usually detected and those not detectable by X-rays. On right panel, 12 sample strips of different lesions (32 exposures are taken in each examination). At bottom, comparison of coverage by different endoscopic instruments (largest with gastrocamera), plus indications and contra-indications of this method.

S-19

Title: The "Lighthouse" and Eleven Other Metaphors in Gynecologic Surgery

Exhibitors: Mitchell J. Nechtow, Walter J. Reich, and Louis Keith

Institutions: Cook County Hospital, Chicago Medical School and Cook County Graduate School, Chicago

Description: In graduate teaching, the use of "cliche" or a "metaphor" will often tell a great deal to the mature and experienced physician. Not only will it convey a clinical and practical message, but the student will rarely forget it. We have used such terms for many years, and frequently when we meet a former student he will address us using the metaphor or some variation of it. Each of the metaphors to be discussed has a specific meaning as to the anatomy and surgical technique used in gynecology. The following twelve metaphors are to be discussed in detail and correlated by appropriate illustrations: The Lighthouse; Forever Amber; Nidar Stritch; Shut Off the Main Valve; The Vaginal Shampoo; P. Straight; Haymaker Stitch; Don't Wait, Ligate; Mattress It; The Rituals; The Pearl Harbor of Gynecology; Round Robin.

S-20

Title: Checkups Are Worthwhile

Exhibitor: T. Howard Clarke

Institution: American Cancer Society, Illinois Division, Inc., Chicago

Description: The exhibit affirms the value of periodic health examinations, particularly with reference to improved end results of treatment of breast, colon, cervix, lung and oral cancer through the presentation of data on detection and treatment experience. Demonstration proctoscopic examinations will be presented and educational materials, free of charge, from the American Cancer Society will also be available.

S-21

Title: Facial Injuries in a Suburban General Hospital: A Five Year Study

Exhibitor: Richard C. Schultz

Institution: Lutheran General Hospital, Park Ridge

Description: The exhibit is an illustrated survey of various aspects of 410 patients with extensive facial injuries treated in a suburban hospital over five years. The common mechanism of automobile crash facial injury as well as associated injuries of the cervical spine is shown. Various statistics, including medical-legal involvement are presented.

S-22

Title: Cooperative Blood Replacement Plan

Exhibitor: Frank E. Trobaugh, Jr.

Institution: Cooperative Blood Replacement Plan, Inc.

Description: The exhibit describes the Blood Replacement Plan which is designed to assist Chicagoland blood banks in meeting their public responsibility and to help the patient solve some of the problems created by the need for blood transfusions.

S-23

Title: **The American Association of Blood Banks**

Exhibitor: **E. A. Dreskin**

Institution: **The American Association of Blood Banks, Chicago**

Description: This exhibit presents the various activities and services provided by or sponsored by the American Association of Blood Banks. The Clearinghouse exchanges, the Inspection and Accreditation of blood banks, the Rare Donor File, the frozen blood storage and other programs have helped make transfusion safer throughout the country.

S-24

Title: **Your Independent Community Blood Bank**

Exhibitor: **Coye C. Mason**

Institution: **Chicago Blood Donor Service, Inc., Chicago**

Description: This exhibit describes the necessary functions of a complete transfusion service; donor procurement, donor interview and screening procedures, processing of blood and blood derivatives, and programs of technical education.

Scientific Motion Picture Program

Scientific movies will be shown continuously from 2 to 4:30 p.m. Monday and from 9 a.m. to 4:30 p.m. on Tuesday and Wednesday.

9:00 to 9:21

PACEMAKING IN CONDUCTION PROBLEMS.

Color, sound, 21 minutes.

Prepared by Richard C. Powers, M.D. and Isa Sejdinaj, M.D., Elgin, Illinois.

The film reviews the principles involved in the surgical and medical management of Stokes-Adams syndrome, including temporary catheter electrode insertion, permanent pacemaking insertion techniques, and a review of the medical aspects of this, including serial electrocardiograms in each of the six illustrative cases.

9:23 to 9:55

CARDIAC FAILURE IN INFANCY.

Color, sound, 32 minutes.

Prepared by Mary Allen Engle, M.D. and Sylvia P. Griffiths, M.D., New York, and John D. Keith, M.D., Toronto, Canada.

The manifestations of cardiac failure in infants and their recognition are demonstrated. General principles of management are shown. Immediate workup including EKG and x-rays, immediate supportive and subsequent therapy, digitalis, diuretics, oxygen, positioning, antibiotics, diet and non-surgical management are illustrated.

9:57 to 10:18

AUSCULTATION OF THE HEART—MITRAL STENOSIS

Color, sound, 21 minutes.

Prepared by Abe Ravin, M.D., Denver, Colorado.

A new electronic heart-sound simulator is demonstrated. With this instrument heart sound and murmurs are synthesized and reproduced with unmatched sound fidelity. Simultaneously, the murmur is demonstrated on an oscilloscope. The sound and image can be slowed without distortion, enabling the sounds and murmurs of mitral stenosis to be dissected for teaching and then reconstituted to the

normal rate. The patho-physiology of the sound projection in this disease is portrayed by animation with synchronized heart sounds. The effects of positioning the patient in auscultation of the heart are demonstrated by means of this heart-sound simulator.

10:20 to 10:41

OFFICE MANAGEMENT OF ANORECTAL LESIONS.

Color, sound, 21 minutes.

Prepared by Raymond J. Jackman, M.D. and Clyde E. Culp, M.D., Rochester, Minnesota.

This film depicts eleven therapeutic and diagnostic procedures that are amenable to office management.

10:43 to 11:10

CANCER IN CHILDREN.

Color, sound, 27 minutes.

Prepared by the American Cancer Society.

This film portrays, by means of case histories, several types of cancer in children. Patients with Wilms' tumor and neuroblastoma are presented in detail. The family physician, the multidisciplinary approach within the medical center hospital, diagnostic facilities, and methods of therapy are presented. Acute lymphatic leukemia is presented in less detail and a child with a "lump" is also shown.

11:12 to 11:41

VISCERAL ORGAN TRANSPLANTS.

Color, sound, 29 minutes.

Prepared by Francis D. Moore, M.D., John P. Merrill, M.D. and Joseph E. Murray, M.D., Boston, Thomas E. Starzl, M.D., Denver, and Dr. Peter B. Medawar, London.

This film deals with the three major problems involved in the transplantation of visceral organs: 1) surgical, 2) immunological and 3) supply. Profuse animation is used to simplify the explanation of the rejection mechanism.

NOON BREAK

2:00 to 2:09

INTRAUTERINE FETAL TRANSFUSION.

Color, sound, 9 minutes.

Prepared by Robert B. Jaffe, M.D., Colin Campbell, M.D., Bruce Work, M.D. and Walter M. Whitehouse, M.D., Ann Arbor, Michigan.

This film depicts the latest refinements of intrauterine fetal transfusion which have improved the prognosis for babies who otherwise would die before 32 weeks gestation, too early for survival if labor were induced. After a review of the spectrophotometric analysis of the amniotic fluid that permits a precise diagnosis of the extent of fetal involvement, the film shows an actual intrauterine transfusion and emphasizes the importance of obstetrical-radiological teamwork for the successful insertion of the catheter for the infusion.

2:11 to 2:31

THE MECHANISMS OF ACTION OF THE ORAL CONTRACEPTIVES.

Color, sound, 20 minutes.

Prepared by Edward T. Tyler, M.D., Los Angeles, Martin L. Stone, M.D., New York, and Melvin R. Cohen, M.D., Chicago.

This film involves a discussion of the effects of both combination and sequential oral contraceptives on the anterior pituitary, endometrium and the cervix. Dr. Tyler serves as moderator and discusses the ovulation inhibiting effect of both types of therapy. Dr. Cohen discusses the effect on cervical mucus, and Dr. Stone reviews the effect on the endometrium.

2:33 to 2:49

URINARY TRACT INFECTION IN GIRLS.

Color, sound, 16 minutes.

Prepared by Colin Markland, M.D., Minneapolis.

This film reviews the importance of a complete urological evaluation in all cases of urinary tract infection in girls. It emphasizes that many urinary tract infections can be silent, and it discusses and illustrates the important role of the urologist in modern day evaluation of these problems, stressing that evaluation now includes voiding cystography, calibration, besides IVP and endoscopic examination. Examples of treatment of currently accepted causes, such as meatal stenosis, urethral obstruction and other forms of outlet obstruction are illustrated and results of nearly two years experience with this type of evaluation at the University of Minnesota are critically reviewed.

2:51 to 3:11

THE OBSOLETE MENOPAUSE.

Color, sound, 20 minutes.

Prepared by Allan C. Barnes, M.D. and Georgeanna Seeger-Jones, M.D., Baltimore, M. Edward Davis, M.D., Chicago, Prof. Hubert de Watteville, Geneva, Switzerland, Robert W. Kistner, M.D., Cambridge, Mass., and Herbert S. Kupperman, M.D., New York.

The troubles associated with menopause are caused by a reduction of estrogen, and can be successfully prevented or treated by supplying the deficient hormone. In the interests of objectivity, the six eminent participants represent the gamut of opinion on such controversial questions as whom to treat, how to treat, when to begin and end treatment, whether or not estrogens are carcinogenic, and the inclusion of a progestin to prevent endometrial hyperplasia. Included is a demonstration of a new device which facilitates the quantitative measurement of osteoporosis in minutes.

3:13 to 3:41

PHYSICAL DIAGNOSIS OF THE EAR, NOSE AND THROAT.

Color, sound, 28 minutes.

Prepared by William H. Saunders, M.D., Columbus, Ohio.

This film shows the exacting details of the ear, nose and throat physical examination. There are three sections: first, the ear; second the nose and paranasal sinuses; third, the oral cavity, nasopharynx, larynx and neck. At the end of the film is a short recapitulation.

3:43 to 4:30

THYROID DEFICIENCY — CURRENT CONCEPTS OF DIAGNOSIS AND TREATMENT.

Color, sound, 30 minutes.

The film brings the viewer to a unique symposium where five prominent endocrinologists discuss the major clinical aspects of hypothyroidism, a constant consideration in the physician's daily practice. Subjects discussed range from pediatric aspects to treatment of myxedema coma. The discussants are Sidney Ingbar, M.D., Boston, J. Thomas Dowling, M.D., Seattle, William M. Jefferies, M.D., Cleveland, Edward Rose, M.D., Philadelphia and Judson J. Van Wyk, M.D., of Chapel Hill, North Carolina

Technical Exhibitors

Booths T-1, T-2 and T-3

DANIELS SURGICAL & MEDICAL SUPPLIES

DANIELS—with Mid-America's Most Ultra Modern Facilities to serve your Modern Professional Needs will again feature the newest in "TOP LINE BRAND" equipment and supplies.

See our individual Model Office Displays—also consult with our Planning, Decorating, Financing, and Service Department at our exhibit.

NEW ITEMS TO BE SHOWN—A Fast New Office Procedure for Blood Glucose, B.U.N., Hemoglobin, Cholesterol, and Uric Acid—L-F Uni-flex Diathermy—CASTLE'S #7 Speedclave—New RITTER'S #XL45 Examining Table—RITTER'S "75" Universal Table with full range 12-Positions Automatic Flexibility. HAMILTON'S New Electrically Operated Table—HAMILTON Modular Furniture—Illuminated Eye Chart—TRI-TONE Audiometer—HUDSON Oxygen Unit—SORENSEN Suction Pump—Electronic Stethoscope—WELCH ALLYN Electrically Illuminated Diagnostic Instruments and the Newest in DISPOSABLE PRODUCTS. Descriptive Literature Is Available on All Products.

Booth T-4

SMITH KLINE & FRENCH LABORATORIES

Featured will be our comprehensive oral diuretic, 'Dyazide', each capsule containing 50 mg. of 'Dyrenium' (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Booth T-5

FLINT LABORATORIES

Featured Products are SYNTHROID and HU-TET . . . SYNTHROID (sodium levo-throxine) Tablets and Injection, the active principle of the thyroid gland, prepared synthetically in pure crystalline form for predictable and stable therapeutic results.

HU-TET (Tetanus Immune Globulin-Human), tetanus antitoxin of human origin for virtual freedom from sensitivity reactions. Now available from Flint Laboratories in 250 unit vials for economical and long-lasting protection.

Booth T-6

U.S. VITAMIN & PHARMACEUTICAL CORPORATION

The U.S. Vitamin & Pharmaceutical Corporation cordially invites you to visit their exhibit where DBI and DBI-TD will be on display.

Professional service representatives will be in attendance to welcome you and to be of help in answering any inquiries pertaining to the products on display, as well as any of their other products.

Booth T-7

APACHE CORPORATION

The function of Apache Corporation is to organize, offer and manage drilling programs for individuals and corporations whose taxable incomes render attractive and justify the inherent risk of oil participation.

Booth T-13

MEDCO PRODUCTS COMPANY, INC.

Presenting the new MEDCO-SONLATOR TWIN, a new concept in therapy. Combining the first significant advance in Ultrasound therapy, selective rate pulsed Ultrasound, synchronized with Muscle Stimulation, and simultaneously applied through a single 3-way sound applicator. A few minutes spent in our booth should prove of value to your practice.

Booth T-20

THE GOOD-LITE COMPANY

The latest in Head-lights: Hi-Lo Stand Light especially for gynecology: Several new Visual Acuity Charts for schools, industry and doctors. Also a practical Pre-School screener.

Booth T-21

MEDIPAK, INCORPORATED

"IF IT MAKES SENSE, TO DISPENSE" . . . YOU can SAVE money, SAVE employee time, SAVE annoyance in pill counting and packaging operations with the MEDIPAK PLAN. Pre-counted and pre-sealed basic drugs, plus a total service plan—the first really new development in this field in many years. Also, provides easy compliance with "Drug Abuse Amendment". The MEDIPAK PLAN will save up to two hours a day of your most valued employees time. Sound good? SEE IT!

Booth T-22

7-UP DEVELOPERS

The organizations that bottle and deliver sparkling, crystal-clear 7-UP and LIKE to the people of Illinois. They will be ready at all times to provide the fresh, clean taste of chilled 7-UP or LIKE for thirsty conventioners.

Booth T-23

G. D. SEARLE & CO.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Ovulen for ovulation control and menstrual disturbances, and Flagyl, a potent, new trichomonacidal agent for trichomonal vaginitis, carvicitis, urethritis and prostatitis.

Booth T-24

LEDERLE LABORATORIES

Lederle Laboratories is proud to support the 1967 Convention of the Illinois State Medical Society. As one of the leaders in medical research and quality controlled production, we present for your consideration products such as DECLOMYCIN®, ACHROMYCIN®V, ARISTOCORT®, LEVOPROME®, and others applicable to your practice. Our representatives in Booth No. 24 are also prepared to provide information on our numerous services to medicine.

Booth T-25

MERCK SHARP & DOHME

The Merck Sharp & Dohme exhibit has been designed to offer a contribution to your therapeutic armamentarium. Technically trained personnel are available to discuss the scope and variety of services offered to physicians.

Booths T-26 and T-27

BLUE SHIELD MEDICAL SERVICE

Booth T-29

HOECHST PHARMACEUTICALS, INC.

Lasix (furosemide) is a new diuretic characterized by: a high degree of efficacy; rapid onset of action comparatively short duration of action; acts not only in the proximal and distal tubule but also at the ascending limb of Henle's loop; low toxicity when properly used. It is indicated for the treatment of edema associated with congestive heart failure, cirrhosis of the liver, and renal disease, including the nephrotic syndrome.

Booth T-30

ESTA MEDICAL LABORATORIES, INC.

The ESTANEEDLE DEVICE provides a RAPID, ECONOMICAL, PAINLESS method of screening a single patient or 450 per hour, for Tuberculin Testing, Vaccinations and Allergy Testing.

The Variables, such as depth of puncture, amounts of materials injected and the subjective readings have almost been entirely eliminated, providing the physician with a much greater validity in the above mentioned procedures.

Booth T-31

THE COCA-COLA COMPANY

"Ice cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Chicago, and The Coca-Cola Company."

Booth T-32

PARKE DAVIS & CO.

Booth T-33

MILLER PHARMACAL COMPANY

Products designed to support the extra requirements of the body's thousands of enzyme systems for minerals, vitamins and amino acids during periods of stress and abnormal nutrition. Because of their satisfaction in prophylaxis and therapy, patients appreciate these truly scientific preparations.

Booth T-34

PROFESSIONAL LIFE & CASUALTY COMPANY

Representatives of the life insurance organization which serves medical men and women, and their families, will be in attendance during the entire meeting. Of particular interest will be the TERM LIFE and the new PARTICIPATING WHOLE LIFE Insurance Plans, both of which are receiving nationwide acceptance in the profession. Either of these plans would prove to be an excellent addition to your insurance portfolio—allowing for a high amount of life insurance benefits . . . at a low net cost.

Booth T-35

MEDTRONIC, INC.

Chardack-Greatbatch Implantable Cardiac Pulse Generators including both implantable and external varieties. Medtronic's Vein Eraser for electro-fulguration of varicose veins will also be displayed.

Booth T-36

WM. P. POYTHRESS & CO., INC.

The Poythress exhibit will feature: TROCINATE, a new concept in smooth muscle spasmolysis, acting directly upon muscle cells. Not an anticholinergic. No side-effects characteristic of autonomic blocking drugs. High therapeutic index. Trocinatate is particularly effective against functional diarrhea, mucous colitis, diverticulitis, spastic ureteritis and bladder spasms.

MUDRANE combinations, established Poythress products for relief of asthma, emphysema, bronchiectasis and chronic bronchitis.

SOLFOTON, maintains mild, continuous sedation around the clock over long periods of time without the patient's usual awareness of sedation.

Booth T-37

AMERICANA CORPORATION

We will be featuring the new edition of the Encyclopedia Americana and the new Book of Knowledge.

Booth T-38

KEY PHARMACEUTICALS, INC.

The following will be displayed: 1. HYASORB PENICILLIN—a sustained action, 250,000 unit, Penicillin tablet, producing detectable 10-hour blood levels. 2. NITROGLYN—Sustained action Nitroglycerin, $\frac{1}{50}$ gr., $\frac{1}{25}$ gr., and $\frac{1}{10}$ gr. Two to three tablets daily help prevent angina. Also, NITROGLYN sublingual $\frac{1}{400}$ th gr., $\frac{1}{150}$ th gr., $\frac{1}{200}$ th gr., and $\frac{1}{400}$ th gr. 3. PROTERNOL—Sustained action isoproterenol HCl, 30 mg. tablets for Stokes-Adams and heart-block patients. 4. THEO-NAR—Two or three tablets daily for long-acting relief of bronchial asthma symptoms. 5. SEDUTAIN—Delayed release Sodium Secobarbital hypnotic.

Booth T-39

INVESTORS DIVERSIFIED SERVICES, INC.

Investors Diversified Services, Inc., with its subsidiary and affiliated companies, frequently referred to as the Investors Group, is unique among the nation's leading financial institutions. It is the largest investment corporation of its kind in the world . . . having currently more than six billion dollars in assets under management, and in excess of 1.4 million customer accounts. From its beginning in 1894 the company has maintained its own sales organization for the purpose of offering its securities directly to the public.

Come in and visit with our local representatives:

FRED E. FISCHER
HAL SCHANOES

Booth T-40

PM-ILLINOIS, INC.

The PM GROUP provides a complete business service for the medical profession. The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc., of Battle Creek, Michigan. It assures PM clients that the knowledge, experience and integrity of the oldest and largest such firm in the country are at their command.

Those in attendance at the Illinois State Medical Society Convention are cordially invited to stop and meet the experienced PM executives there.

Booth T-41

CIBA PROFESSIONAL SERVICE

CIBA Professional Service representatives will be pleased to discuss Esimil.

Booth T-42

ELI LILLY & COMPANY

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance welcome your questions about Lilly products. You may be particularly interested in discussing KEFLIN® Cephalothin.

Booth T-43

SANDOZ PHARMACEUTICALS

Sandoz Pharmaceuticals cordially invites you to visit our display at booth #43, where we are featuring Mellaril, Sansert, Cafergot P-B, Fiorinal and Fiorinal with codeine.

Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

Booth T-44

PARKER, ALESHIRE & COMPANY

As the administrators of the officially sponsored Group Disability Plan and Group Major Medical Plan for members of the Illinois State Medical Society, we invite you to drop by our booth and discuss these fine programs with our representatives.

Both plans provide broad coverage that cannot be duplicated under an individual policy at the comparable premium cost to you. Review your group insurance NEEDS TODAY!

These programs are another benefit of your membership in the Illinois State Medical Society and deserve your consideration.

Booth T-45

CARNATION COMPANY

Carnation Company cordially invites you to visit Booth #45, where Medical Representatives will be pleased to welcome members and guests of the Illinois State Medical Society.

Recent literature and information regarding Carnation Evaporated, Breakfast and Carnalac are available.

Any question pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

Booth T-46
THE NATIONAL DRUG CO.

Booth T-47
PFIZER LABORATORIES

The Pfizer Laboratories' display has been specifically arranged for your convenience and to give you the maximum in quick service and product information.

To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to discuss with you the latest developments in Pfizer research.

Booth T-48
SIEMENS MEDICAL OF AMERICA INC.

Medical technology has brought about great advancements. The SIEMENS line, on display, offers the latest in diagnostic and therapy equipment.

Few minutes at our exhibit will be most informative.

May we look forward to greet you.

Booth T-49
PEPSI-COLA GENERAL BOTTLERS

Our booth will consist of: One portable 6 foot bar and an ice-cooled attendant unit. We will supply a girl to sample our products of Pepsi, Diet Pepsi and Mountain Dew.

Booth T-50
MEAD JOHNSON LABORATORIES

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Booth T-51
GEIGY PHARMACEUTICALS

Geigy Pharmaceuticals cordially invites Members and Guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of cardiovascular disease as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

Booth T-52
ABBOTT LABORATORIES

Abbott Laboratories cordially invites you to visit our exhibit. Our professional representatives will be happy to answer any questions you may have concerning our leading products and new developments.

Booth T-53
THE UPJOHN COMPANY

Professional representatives of the Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Booth T-54
ASTRA PHARMACEUTICAL PRODUCTS, INC.

Information and descriptive literature pertaining to Xylocaine® (lidocaine) and Citanest® (propitocaine) local and topical anesthetics, and iron preparations Astrafer® (dextriferron) for intravenous use and Jectofer® (iron sorbitex) for intramuscular administration will be available at the Astra booth presided over by our representative, Mr. John R. Geis.

Booth T-55
BEUTLICH, INC.

BEUTLICH, INC. will feature PERIDIN-C, for the non hormonal control of the menopausal hot flash, MANDALAY, the new dual layered methenamine mandelate tablet, and CEO-TWO, the carbon dioxide enema like suppository will be shown.

Booth T-56
THE MEDICAL PROTECTIVE COMPANY

With Exceptional proficiency in defense, so essential to the Doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim for damages based on professional services rendered or which should have been rendered. Its experience from the successful handling of 92,000 claims during 68 years of Professional Protection Exclusively is unparalleled in the professional liability field.

Booth T-57
MEDICAL BUSINESS CONSULTANTS, INC.

You may be surprised at the unusual savings available to you. Savings in your time, taxes, and office costs are secured through analysis and recommendation on a monthly—or single occasion—basis. We'll be happy to explain how your colleagues are conserving more of their earnings through specialized management, financial, and tax planning.

Booth T-58
AUDIO-DIGEST FOUNDATION

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals,

plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in seven series—General Practice, Surgery, Internal Medicine, Obstetrics & Gynecology, Anesthesiology and Ophthalmology.

Digest subscribers listen in their car, home or office. Carefully selected tape equipment for playing the Digests is offered at the convention by Pacific Medical Equipment Co.

Booth T-59

W. B. SAUNDERS COMPANY

New Saunders books of special interest published since last year's meeting include—Current Therapy 1967; Beckman: Dilemmas in Drug Therapy; Criepp: Allergy; Frieboes: Color Atlas of Dermatology; Adrian: Labat's Regional Anesthesia; Bakwin and Bakwin: Behavior Disorders in Children; and Conn, Clohecy and Conn; Current Diagnosis.

Booth T-60

E. R. SQUIBB & SONS, INC.

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.

Booth T-61

AYERST LABORATORIES

Ayerst Laboratories extends an invitation to visit our exhibit where Mediatric and Thiosulfil are being featured. Our representatives will be pleased to discuss these or other Ayerst products with you.

Booth T-62

CONTOUR CHAIRS

Booth T-63

ARNAR-STONE LABORATORIES, INC.

AMERICAINE TOPICAL ANESTHETIC—20% dissolved benzocaine in a water-soluble base—ointment, liquid, suppositories and aerosol forms. Aerosol operates rightside up or upside down for contortion free application.

HAZEL-BALM—A "medicated cushion of foam" combines cooling, soothing witch hazel with emollient water-soluble lanolins. Wide range of usefulness in office and hospital practice.

ISOCOLOR—Oral nasal decongestant and bronchodilator—tablet, liquid and timesule forms, also the anti-tussive Isoclor expectorant.

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Oregon Senator to Speak at Annual Public Affairs Dinner May 22

The Hon. Mark O. Hatfield, United States Senator from the State of Oregon, will present the Camp Memorial Lecture May 22 at the annual Public Affairs Dinner of the Illinois State Medical Society. The dinner will begin at 6 p.m. in the Bal Tabarin of the Sherman House, Chicago.

Senator Hatfield served two terms as governor of Oregon before being elected to the Senate last fall. Previously he had been Oregon's Secretary of State, a state representative and state senator. He has held numerous posts in the Republican party and was chosen to nominate Richard M. Nixon for President in 1960.



Senator Mark O. Hatfield

Dinner Dance

Honoring

Caesar Portes, M.D.

President, Illinois State Medical Society

Featuring

Chuck Cavallo

and his society orchestra direct from the Ambassador
and Drake Hotels

Reception 6:30 p.m.
Dinner 7:30 p.m.
Dancing 9:00 p.m.

Tuesday, May 23
George Bernard Shaw Room
Sherman House, Chicago

House of Delegates *(Continued from page 450)*

(3) In preparing the resolution, it is wise to avoid too many and too long "WHEREAS"'s

(4) Place only ONE action in each resolution to avoid a motion from the floor "to divide" . . . or the defeat of the entire resolution because of adverse reaction to a portion of the material presented.

(5) Address your resolution specifically to the Illinois State Medical Society House of Delegates. (Rewrite the action taken at the local county medical society level, and see that it applies to the State Society level for state wide action.)

(6) Many resolutions which are self-explanatory, are presented without any "whereas"'s.

(7) Be present at the opening meeting of the House of Delegates to introduce officially the resolution you wish to have submitted.

(8) Appear before the reference committee to discuss the resolution in detail and to present the opinions of your society.

(9) Any delegate may present a personal resolution if he so desires, or if time for county medical society action was not available.

(10) Submit all resolutions as early as possible so they can be published in the Illinois Medical Journal, circulated to the other county medical societies, and discussed prior to the meeting.

What Are the Responsibilities of a Delegate?

(1) To attend all THREE sessions of the House of Delegates: Sunday afternoon, Tuesday and Wednesday afternoons.

(2) To become familiar with the reports, resolutions to be considered, and to determine the feelings of his local society so that he may represent his constituents on the floor of the House and before the reference committees, and so that his vote on the floor of the House will be in keeping with his "grass roots" instructions.

(3) To be familiar with the final reports of the reference committees as approved and/or amended; to be aware of the actions of the House as summarized and mailed by headquarters immediately following the adjournment sine die, of the House, and to report in detail to his county or branch society.

As a delegate, he is an important link in the chain of communications between the House of Delegates and the membership of the Society.

What Powers Are Not Assigned to the House of Delegates?

(1) The Board of Trustees "shall implement all mandates from the House EXCEPT IN THE MATTER OF PROPERTY OR FINANCE, when it shall have sole authority."

Bylaws—Chapter VI, Section 2

The House may recommend expenditure of funds, but the Board has full charge and control of all "property of whatsoever nature and of all funds from whatsoever source belonging to the Society."

The Board recommends the amount of dues for the ensuing year, but the House takes action thereon.

(2) The Board of Trustees acts as the board of censors of the Society, and has jurisdiction over all questions of ethics and in the interpretation of policies or laws of the Society.

All questions of an ethical nature before the House of Delegates or any scientific meeting "shall be referred to the Board of Trustees without discussion."

President's Page

(Continued from page 414)

confidence. Listen to him, take his advice. He will help to keep them well.

Today, the quacks are hard to recognize. Most of them are fairly well educated and respectable appearing persons who have a little bit of knowledge of medical terminology. They have nice bedside manners, show an interest in the individual and are very impressive. But we must make the public understand that these people, these men, are to be evaded.

How then can a non-medical person recognize the health quack? Congress on medical quackery has suggested the following guide lines.

1. The quack often uses a special, unorthodox or "secret" formula or machine that he claims can cure disease.

2. He may promise or imply a quick or easy cure, or he may talk about "pepping up" your health.

3. He advertises, using his "case histories" and testimonies from his "patients" to impress people.

4. He refuses to accept the tried and proved methods of medical research and proof. He clamors constantly for "medical investigation" and recognition, but he avoids a test or stops short of giving the data needed for scientific evaluation.

5. He claims medical men are persecuting him or that they are afraid of his competition.

6. He claims that his method of treatment is better than certain surgery, x-rays, and drugs prescribed by a physician.

There are different types of quacks; they come in many forms. There is the health food fadist who claims to prevent or cure all diseases by specific health foods or regimen consisting of fruit juices and enemas several times a day. Then there is the quack who claims to cure all diseases by the laying on of hands, massage or manipulation. Then there are the naturopaths, those who feel all diseases and illnesses can be cured by a drugless system of treatment, employing the use of forces such as air, light, heat, water, massage, etc. Then

there is the mechano-therapist who advocates treatment by mechanical means, certain machines. Of course, of all the cultists, the Chiropractors are the most numerous and because of their number, present the greatest danger for the uninformed public.

However, this is not all, we must direct our attention and criticism towards the newspapers, magazines, radio and television. These media accept advertisements of drugs, used in the treatment of such diseases as diabetes, arthritis, cancer, tuberculosis, heart disease and many others. I think that the medical profession and the medical society has been lax in this respect. We must make an effort to enlist the aid of these media to refuse to accept advertisements of this kind without specific approval of the medical profession.

How many of you have heard about these five New York doctors that claim they have a little pill that can cure many diseases, etc., etc.. What about this drug that's spelled backwards that can make you a regular person again? What about this ointment that is supposed to cure hemorrhoids without surgery, and, of course, you've seen this white stuff that is supposed to coat the inside of the stomach and neutralize all your acid that is necessary for good digestion. These and many others too numerous to mention, are advertised freely, with documentation, without supervision, without approval by the medical profession. This must be stopped. We must make an effort to direct these people in the proper channels. We must prevent this kind of reckless advertisement because all it leads to is the ill health of the public of this country.

I feel that the medical profession must make every effort in the direction of combatting quackery. It is just too bad that this article is written in a journal which is directed towards the doctors. I am certainly sure that the doctors are quite aware of this situation and that this should be rather directed to the public. The public should realize. The public should be aware of this. The public should be educated and informed about the quackery that is existing in the United States. While this article is being published in the Journal of the Illinois State Medical Society, I would hope that perhaps the doctors would ask for some reprints if they think it is worthwhile, to place

in their offices so that their patients may pick it up and read about it. We must try to reach the public. This is our responsibility. We as doctors are interested in the welfare and health of the public of the

United States, and anything that we can do to prolong life, to keep our people healthy, we must bend ourselves in that direction.

Caesar Portes, M.D.

— THE VIEW BOX —

DIAGNOSIS AND DISCUSSION

(Continued from page 443)

DIAGNOSIS: Villonodular synovitis.

This is a benign tumor of the synovial membrane occurring in young people. The tumor proliferates in the synovia and may occasionally involve the underlying bone by pressure or invasion of the abnormal tissue. The margins of bone invasion are sharp and sclerotic and in our case, involve the femoral neck and acetabulum as well.

As in all tumors of bone, a biopsy is necessary for final evaluation as other lesions can mimic these radiographic findings. However, the fact that the lesion is limited to one joint, and is not associated with systemic illness in a young adult narrows the field considerably.

In a tuberculous arthritic we would expect the joint to be narrowed and the femur to show evidence of osteoporosis. The appearance of multilobular soft tissue swelling is highly suggestive of the condition. In our case this was present at surgery but is not visualized on the radiograph (probably because of the heavy musculature about the thigh). Synovioma may be difficult to differentiate; however, the smoothness of the bony lesions is usually not a feature of this condition. Biopsy is the only true differentiation.

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ATARAX[®]

(hydroxyzine HCl) tablets, syrup

Product Information

Contraindications: Use in pregnancy:

When administered to rats at doses substantially above the human therapeutic range, hydroxyzine induced fetal abnormalities. Until human clinical data are available adequate to establish safety in early pregnancy, hydroxyzine is contraindicated in early pregnancy. The drug is contraindicated for patients who have shown previous hypersensitivity to it.

Precautions: Hydroxyzine HCl may potentiate narcotics, barbiturates, meperidine and other CNS depressants. In conjunctive use, dosage of these drugs should be reduced by as much as 50 per cent. Atropine and other belladonna alkaloids are not affected by hydroxyzine. Because drowsiness may occur, patients given hydroxyzine should be cautioned against driving a car or operating dangerous machinery.

Adverse reactions: No serious side effects resulting from the oral administration of hydroxyzine have been reported and confirmed to date. Therapeutic doses seldom produce impairment of mental alertness. The transitory drowsiness that may occur usually disappears spontaneously in a few days of continued therapy or can be corrected by dosage reduction. Dryness of the mouth may be encountered at higher doses.

The absence of toxic effects on the liver and bone marrow has been demonstrated by extensive clinical use at recommended doses for more than four years of uninterrupted therapy and by experimental studies in which excessively high doses were given. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with considerably higher than recommended doses.

Dosage: Ranges from 25 mg. t.i.d. to 100 mg. q.i.d.

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J.B. ROERIG DIVISION
CHAS. PFIZER & CO., INC.
NEW YORK, N.Y. 10017

NEW

PHARMACEUTICAL

SPECIALTIES

by Paul deHaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

NEW SINGLE CHEMICALS

MACLATE Muscle Relaxant—General R
Manufacturer: The Upjohn Company

Nonproprietary Name: Chlorphenesin carbamate

Indications: Strains, sprains, and direct trauma involving the neck, back and joints; disc syndrome; synovitis-tendinitis; fibromyositis-myositis; osteoarthritis; rheumatoid arthritis.

Contraindications: During pregnancy, in children, and in patients who have demonstrated evidence of hypersensitivity to it.

Dosage: One tablet, 4 times daily, up to two tablets 3 times daily.

Supplied: Tablets—400 mg.; bottles of 50 and 500.

DUPLICATE SINGLE PRODUCTS

SOPOR Hypnotics & Sedatives-Nonbarbiturate R

Manufacturer: Arnar-Stone Laboratories

Nonproprietary Name: Methaqualone

Indications: To provide sleep and daytime sedation.

Contraindications: Severe hepatic impairment, during pregnancy, and children under 14 years of age.

Dosage: For sleep—150 to 300 mg. before retiring. For sedation—75 mg. after each meal and at bedtime.

Supplied: Tablets—150 mg.; bottles of 100, 500, 1000.

COMBINATION PRODUCTS

NORINYL-1 Progesterone/Estrogen Combination R

Manufacturer: Syntex Laboratories

Composition: Norethindrone 1.0 mg.
Mestranol 0.05 mg.

Indications: Oral contraception

Contraindications: History of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breast or genital organs, undiagnosed vaginal bleeding.

Dosage: One tablet daily for 20 days, beginning on day 5 of the menstrual cycle.

Supplied: Dispensers—20 and 60 tablets.
Bottles—250 tablets.

(Continued on page 593)

Geigy

Tandearil®
oxyphenbutazone

helps osteoarthritic
joints move again



Please see ad-
joining page for
brief prescribing
summary.

TA-4919 PC

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3 out of 4 osteoarthritics com-
pletely or markedly improved

76.9% of 407 patients

84.6% of 39 patients

Tandearil®

oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

for April, 1967

New Smallpox Vaccination Forms

"To be valid for international travel, smallpox vaccinations performed this year must be recorded on the new certificates," Dr. Franklin D. Yoder, director of the Illinois Department of Public Health, has announced.

Some of the old forms, "International Certificate of Vaccination," are still being received by the department from both physicians and travelers requesting official stamping. These are being returned without the approval stamp. Dr. Norman Rose, chief of the Bureau of Epidemiology, said that no old-type certificate may be officially stamped.

Courses in Medical Librarianship

Courses in Medical Librarianship, approved by the Medical Library Association, will be offered in the summer of 1967 at the following library schools:

Columbia University School of Library Service, July 3-Aug. 11; Emory University Division of Librarianship, June 17-July 28; University of Illinois Graduate School of Library Science, June 26-July 27; University of Michigan Department of Library Science, June 27-July 21; and University of Southern California School of Library Service, June 19-July 28.

May 1—The Children's Hospital of Philadelphia and the department of pediatrics of the University of Pennsylvania's School of Medicine announce a five-day refresher course in pediatrics for pediatricians and general practitioners. Registration and inquiries should be sent to the Children's Hospital, 1740 Bainbridge St., Philadelphia, Pa. 19146.

New Pharmaceutical Specialties

(Continued from page 591)

VITAMIN B COMPLEX

w/Vitamin C Vitamin Combination—Other B
Manufacturer: Wyeth Laboratories

Composition: Thiamine HCl (B ₁)	10.0 mg.
Riboflavin (B ₂)	2.5 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl (B ₆)	2.5 mg.
d-Pantothenyl Alcohol	2.5 mg.
Ascorbic Acid	75.0 mg.
Preserved with 2.5 mg. phenol and 20.0 mg. benzyl alcohol.	

Indications: Vitamin B complex and vitamin C deficiencies.

Contraindications: None mentioned.

Dosage: 2 cc. i.m., daily.

Supplied: Tubex—2 cc.; packages of 10.

**Os
frontale**

**Sinus
frontalis**

**Crista
galli**

**Os
nasale**

Lamina cribrosa ossis ethmoidalis

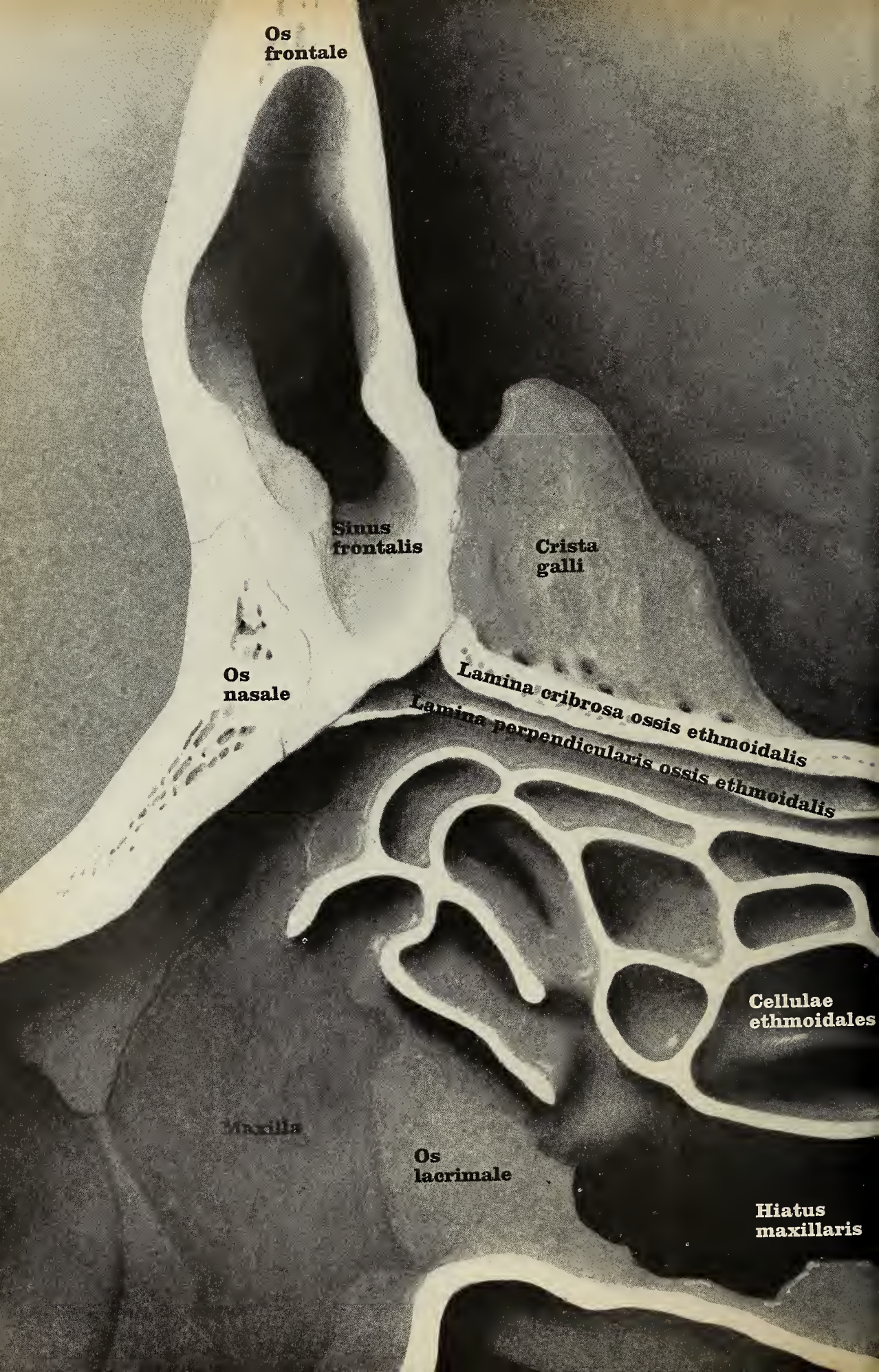
Lamina perpendicularis ossis ethmoidalis

**Cellulae
ethmoidales**

Maxilla

**Os
lacrimal**

**Hiatus
maxillaris**



special formula for a special problem

*specifically formulated
for symptomatic
relief of sinus headache*

Sinus headache is not a single entity, but a chain reaction of pain. It is facial pain—deep, dull, aching and nonpulsating. It is referred pain—originating in the nose and sinuses but felt at another site. It may become generalized pain and tension in head and neck. It is one or all of these.

The Sinutab formula is designed for symptomatic relief of sinus headache.

It provides two analgesics to relieve pain and discomfort... an effective oral decongestant to reduce mucosal congestion... and an antihistamine to help control allergic manifestations.

Side Effects: Epigastric distress, drowsiness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive or operate machinery if drowsiness occurs.

Use with caution in patients with thyroid disease, heart disease, hypertension, diabetes or kidney disease. Excessive dosage or prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

WARNER-CHILCOTT
Morris Plains, N.J.



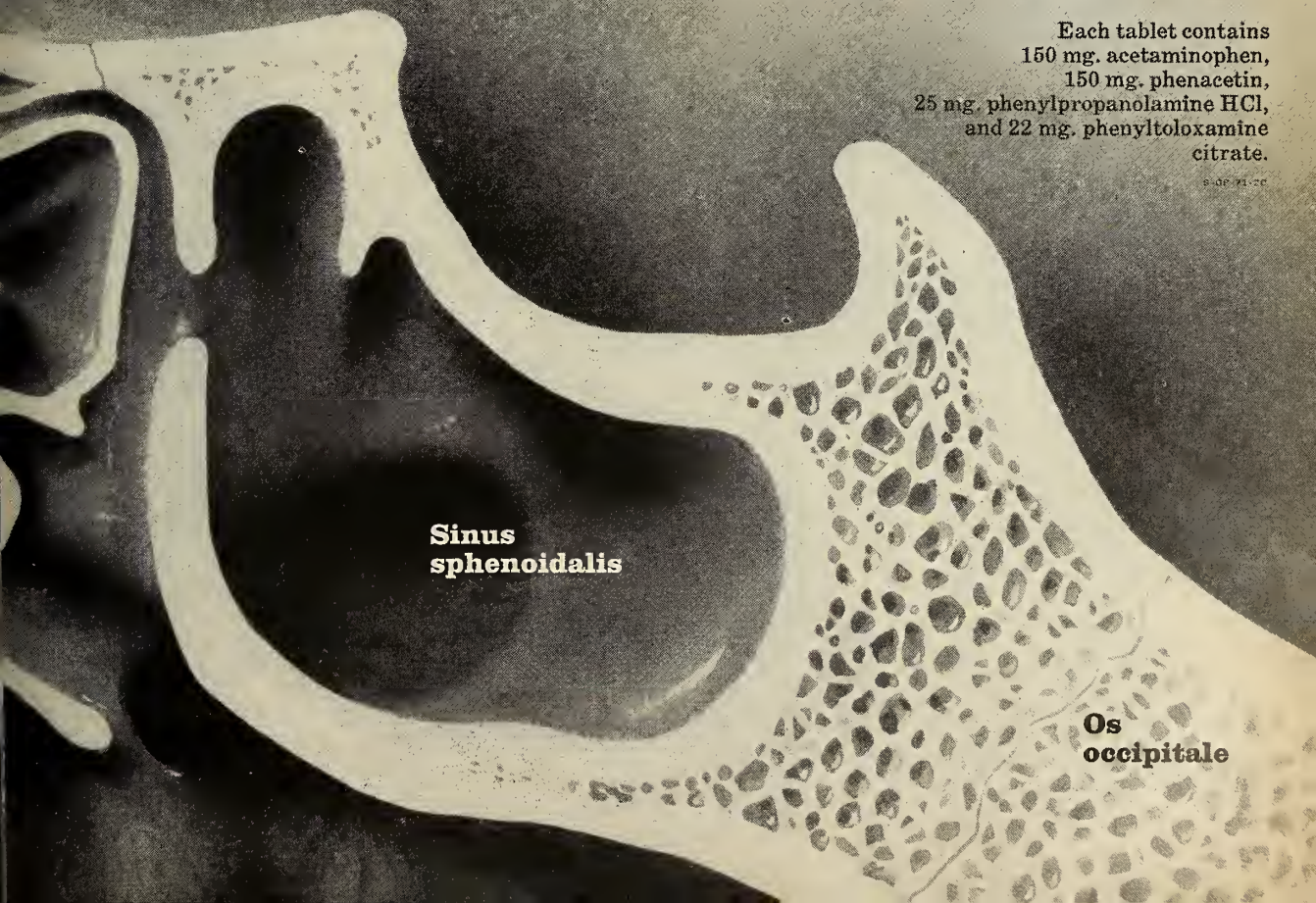
SINUTAB[®] for sinus headache

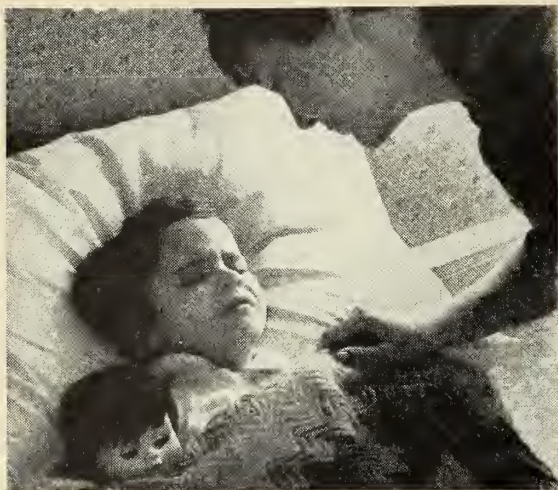
Each tablet contains
150 mg. acetaminophen,
150 mg. phenacetin,
25 mg. phenylpropanolamine HCl,
and 22 mg. phenyltoloxamine
citrate.

MADE IN U.S.A.

**Sinus
sphenoidalis**

**Os
occipitale**





One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
... soothes colicky pain with paregoric*
... consolidates fluid stools with pectin
... adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem,
or simply nervousness and anxiety, Parepectolin
will bring the diarrhea under control until etiol-
ogy can be determined. In some cases, Parepec-
tolin may be all the therapy necessary.



Parepectolin®

Each fluid ounce of creamy white suspension contains:

*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium ($\frac{1}{4}$ grain) 15 mg. per fluid
ounce.

warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Adult Dose: One or two tablespoonfuls three
times daily.

Usual Children's Dose: One or two teaspoonfuls three
times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

596

The Doctor's Library

STEREOSCOPIC ATLAS OF MASTOIDOTYMPANOPLASTIC SURGERY. By Harold F. Schuknecht, Werner D. Chasen, and John M. Kurkjian. The C. V. Mosby Co., St. Louis, 1966. 91 pages, \$26.50.

The "Stereoscopic Atlas of Mastoidotympanoplastic Surgery" could well serve as a model in the publishing field. It unites a well executed verbal and visual description of pathology and technic, and in doing so brings to many a learning experience only surpassed by individual instruction. Including not only the pathology found in chronic ear disease and the authors' personal surgical approach to its eradication, but also an illustrated manual for the removal of temporal bone specimens and an outline for their use in anatomical study, the book has special value for those involved in the teaching (or learning) of otological surgery. The teaching merits referred to above are accomplished by a clear concise text, excellent reproduction of well selected photomicrographs, and especially to the inclusion of an ample set of color stereophotographs taken during actual dissection which are further amplified by a series of line drawings which clarify the photographic details.

The reviewer, on the other hand, does not at all agree with many points of the authors' surgical teaching philosophy and wonders about the merits of presenting in such a powerful way a procedure which is not entirely accepted in the otologic world. Also a procedure whose rather universal application and "simplicity" provides ease in the surgical training of resident physicians does not necessarily provide the best answer for the individual patient in whom, as the authors point out, there may be an extreme variation in the type and extent of pathology. In presenting arguments for the merits of this procedure, the authors make some statements which could have serious medical legal repercussions. "The use of artificial struts, ossicular interpositions, and cartilagenous and bony grafts introduces a factor of uncertainty into the results and must be considered as an experimental technic at this time" is a definite statement concerning

(Continued on page 602)

**ILLINOIS
MEDICAL
ASSISTANTS
ASSOCIATION
REPORT**



Career Days and College Nights

By RUTH CHRISTENSEN

The medical field is one of the largest industries in the United States today. Like all industries it has its problems. One of the big problems facing the medical field today is that the training of personnel such as medical assistants, nurses, x-ray technicians, medical technologists, therapists, dieticians, etc., have not kept pace with the expansion of the industry.

Medical assistant chapters throughout the state and country are taking active part in high school Career Days in their local areas. The Kane County Medical Assistants Association is an example. They made contact thru councilors at the high schools. After being briefed on the general content of the talk to be presented and the specific area of the medical assistant's professional background (that is, whether she was a secretary-receptionist, nurse, technician, therapist etc. or a combination of several of these), the high school scheduled a period for the presentation of this material. It also gave the medical assistant information about the length of time she had to speak, and the possible number of students to whom she would be speaking, based on the record of attendance for previous years. The medical assistant usually speaks for half the allotted time, and allows the remainder for questions and answers.

Also very active in this program are the members of the McHenry County Medical

Assistants Association, whose members are participating in College Nights or Career Days in the high schools to discuss the advantages of becoming a medical assistant with the students. Their members always appear in uniform and talk with interested students, presenting each one with a copy of *Horizons Unlimited*, an AMA booklet. They also present literature made available by the American Association of Medical Assistants and inform them of the certification program.

Most frequently asked questions are "How do I go about becoming a medical assistant?", "What training do I need?", "Where do I get such training?", and "What should I take in school now to prepare me for further formal training?" Where the student shows an interest in a branch of medicine where training programs are AMA approved, such as nursing, medical technology, or x-ray technology the student is advised to write to the AMA for a list of approved schools in that field. In the case of medical assisting, per se, the student is advised to check with AAMA about the school of their choice. The AAMA approval program is now underway thanks to a recent contribution from Lederle Laboratories, but is still too new for lists of approved schools to be available.

Those who participate in this program feel that it is a very exciting and rewarding effort.

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- BRONCHIECTASIS

*The
fast-disintegrating
uncoated tablet
gives relief in
15 minutes*

Each tablet contains:

Potassium Iodide.....	195 mg.
Aminophylline.....	130 mg.
Phenobarbital, Caution: May be habit forming....	21 mg.
Ephedrine HCl.....	16 mg.

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of
water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856



Doctor's Library

(Continued from page 596)

technics which have been used for many years and are widely accepted; but which, when brought into legal action as coming from a hallowed institution such as Harvard University, could create great difficulties for many in the otologic fraternity.

In spite of the above reservations, this book is highly recommended to all in otology because of its many merits. The design of this book could be utilized in many areas of medical teaching so its appraisal is urged for those in medical education.

David F. Austin, M.D.

FRACTURE PROBLEMS. Harris, W. H., Jones, W. N., and Aufranc, O. E. The C. V. Mosby Co., St. Louis, 1965.

This book is subtitled "Problem Cases from Fracture Grand Rounds at the Massachusetts General Hospital" and is based upon cases published as the "Fracture of the Month" in the Journal of the American Medical Association, from July, 1960, to July, 1964.

The book is organized strictly on a case-presentation basis and is divided into nine sections, eight of which are related to specific skeletal areas of the body, such as The Leg, The Femur, The Hip, The Spine, and concludes with a section on Pathological Fractures. The contribution of staff members with multiple talents is emphasized and is evident by the participation of surgeons from general surgery, plastic surgery, and urology, as well as orthopedic surgeons.

The case histories are carefully prepared and well edited. The pertinent material is presented succinctly.

Although most of the illustrations which depict the injuries are devoted to reproductions of x-rays, there are sufficient illustrations of the injured parts and five figures in color which enhance the text.

Sound basic principles are presented throughout. The necessity for preparation of the patient for operation is emphasized, including the need for tetanus immunization, antibiotic therapy, and whole blood to combat hypovolemia. There is a short but interesting discussion of fat embolism. The management of fractures in children is considered. Lumbar vertebral fractures in postmenopausal women is discussed.

The book should be of particular interest

(Continued on page 618)

You can't set her free. But you can help her feel less anxious.

You know this woman.

She's anxious, tense, irritable. She's felt this way for months.

Beset by the seemingly insurmountable problems of raising a young family, and confined to the home most of the time, her symptoms reflect a sense of inadequacy and isolation. Your reassurance and guidance may have helped some, but not enough.

SERAX (oxazepam) cannot change her environment, of course. But it can help relieve anxiety, tension, agitation and irritability, thus strengthening her ability to cope with day-to-day problems. Eventually—as she regains confidence and composure—your counsel may be all the support she needs.

Indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression.

May be used in a broad range of patients, generally with considerable dosage flexibility.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. One patient exhibiting drug dependency by taking a chronic overdose developed upon cessation questionable withdrawal symptoms. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6 to 12 year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever, euphoria and dysmetria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

To help you relieve anxiety and tension

Serax[®]
(oxazepam)



Wyeth Laboratories
Philadelphia, Pa.

The HOSPITAL OF CHOICE

North Shore Hospital, a 65-year-old psychiatric facility located on Lake Michigan in Winnetka, Illinois, is an intensive care hospital.

An open staff institution, it provides, through its house and attending staff, a total range of psychotherapies and those related activities which round out a comprehensive treatment program.

A new Half Way Hall, situated in the hospital, has been opened to provide relative freedom of movement in an environment designed to stimulate recovery and provide a necessary phase of interim residence.

A completely open section is a feature of North Shore Hospital's residential plan.

An adolescent program offers boys and girls of high school age a closely-structured program of daily care, with daily classroom attendance and individual tutoring emphasized.

The adjunctive therapies are manned by certified personnel. Occupational and recreational activities not only help structure the patient's day, but offer creative programs in which patients participate according to their emotional health and native capacity.

A therapeutic education program has been introduced for all patients. Medicare patients are offered special attention and remotivation activities.

Psychiatric testing and evaluation is offered, as is individual and group therapy, chemotherapy and the traditional modalities employed in the treatment of emotional illness.

In reputation, performance and location, North Shore Hospital is the psychiatric hospital of choice.



For information, contact:
MILTON A. DUSHKIN, M.D.
Medical Administrator
Telephone: 312-446-8440
225 Sheridan Road, Winnetka, Illinois
(Write for Brochure)

Clinics for Crippled Children

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will count 18 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and three for children with cerebral palsy. Clinicians are selected from among private physicians who are certified board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

May 2, Pittsfield—Illini Community Hospital

May 2, Fairfield—Fairfield Memorial Hospital

May 3, Hinsdale—Hinsdale Sanitarium

May 4, Litchfield—Madison Park School

May 4, Peoria Cerebral Palsy (A.M.)—Roosevelt School

May 4, DuQuoin—Marshall-Browning Hospital

May 4, Sterling—Community General Hospital

May 9, East St. Louis—Christian Welfare Hospital

May 9, Peoria General—Children's Hospital

May 10, Champaign-Urbana—McKinley Hospital

May 10, Joliet—Silver Cross Hospital

May 11, Springfield General—St. John's Hospital

May 12, Chicago Heights Cardiac—St. James Hospital

May 16, Alton General—Alton Memorial Hospital

May 17, Rock Island Cerebral Palsy—Foss Home, 3808 Eighth Ave.

May 17, Evergreen Park—Little Company of Mary Hospital

May 18, Decatur—Decatur & Macon Co. Hospital

May 18, Rockford—Rockford Memorial Hospital

May 18, Elmhurst Cardiac—Memorial Hospital of DuPage County

May 23, Peoria General—Children's Hospital

May 24, Centralia—St. Mary's Hospital
 May 24, Springfield Cerebral Palsy (P.M.)—
 Clinic site to be announced
 May 24, Elgin—Sherman Hospital
 May 25, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital
 May 26, Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the national foundation and other interested groups. In all cases, the work of the division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Meeting Memos

Apr. 26—Symposium on Psychedelic Drugs, co-sponsored by the Catholic Physicians' Guild of Chicago and the Chicago Society of Anesthesiologists, at 8 p.m. in the auditorium of the Hektoen Institute for Medical Research, 627 S. Wood St., Chicago. The program will include the Rev. Albert Moraczewski, O.P., neuro-pharmacologist for the Priory Press, Chicago, speaking on "The Sources of Hallucinogenic Agents and Their Use;" Dr. Daniel X. Freedman, chairman of the department of psychiatry at the University of Chicago, remarks on "Mechanisms of Response to Psychedelic Agents," and Dr. Alexander Karzmar, chairman of the department of pharmacology at Loyola University, on "Behavioral Aspects."

Apr. 30—The International College of Surgeons will open a five-day meeting at the Americana Hotel in Bal Harbour, Fla. Dr. Edward L. Compere, Chicago, president of the college, will preside, and Dr. Edward R. Annis, past president of the American Medical Association, will be one of the principal speakers.

EAST-WEST SEMINAR ON FAMILY AND GROUP PSYCHOTHERAPY

**A Conclave of Psychiatrists from
Eastern Europe, Western Europe,
and North America**

sponsored by
**The Forest Hospital Foundation and
Northwestern University**

Saturday, May 13 — Sunday, May 14

at **FOREST HOSPITAL**
555 Wilson Lane
Des Plaines, Illinois
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Co-Chairmen: Jules Masserman, M.D.;
 Rudolph G. Novick, M.D.;
 Mortimer Gross, M.D.

Participants:

Nathan Ackerman, M.D., New York
 G. Avrutsky, M.D., Soviet Union
 Zoltan Boszormenyi, M.D., Hungary
 Leon Chertok, M.D., France
 D. Muller-Hegemann, M.D., Germany
 Karoline Jus, M.D., Poland
 Don D. Jackson, M.D., California
 F. Knobloch, M.D., Czechoslovakia
 Juan Lopez-Ibor, M.D., Spain
 Louis Miller, M.D., Israel
 J.K.W. Morrice, M.D., Scotland
 Orhan M. Ozturk, M.D., Turkey
 Nikola Schipkowensky, M.D., Bulgaria
 George Vassiliou, M.D., Greece
 Carl Whitaker, M.D., Wisconsin

Reservations: \$25 per person
Attendance limited to 150

OBITUARIES

***Dr. Walter S. Broker**, 73, died Feb. 25 in Florida. Former superintendent of St. Clair County's tuberculosis hospital, he was a member of the St. Clair County Medical Society and was a fellow of the American College of Chest Physicians.

***Dr. Martin J. DiCola**, Chicago, died Feb. 28 at the age of 64. An obstetrician and gynecologist who served on the staff at Chicago Wesley Memorial Hospital, he was associated with the Chicago Maternity Center and the Northwestern University School of Medicine.

***Dr. John F. Edwards, Jr.**, died Feb. 16 at the age of 44 while vacationing in Honolulu, Hawaii. He was deputy medical examiner for Clinton county and a radiologist at St. Joseph's Mercy Hospital in Clinton.

Dr. W. J. Ritchie, died Feb. 5 at the age of 94 at his home in Oak Park where he had lived since his retirement from practice in Rockford. He was a member of the Masons and the American Medical Association.

***Dr. A. Louis Rosi**, Chicago, died March 3 at the age of 60. A physician practicing for 30 years, he was on the staffs of the Little Company of Mary and Roseland Community hospitals. A scholarship is being established in his name at the University of Chicago where he did undergraduate work.

***Dr. Franklin L. Rubright**, Rock Falls, died Feb. 25 at the age of 71. He founded The Home Hospital, Sterling, in 1933 and was its administrator and chief of staff at the time of his death. He was a member of the Bureau of Aeronautics and a Fellow of American College of Surgeons.

We are delighted to announce, but embarrassed to admit that we erroneously published an obituary for Dr. Earle H. Thomas in the September issue. Dr. Thomas assures us that he is hale and hearty and enjoying life in Lake Wales, Florida. We regret any inconvenience or awkwardness this publication may have caused him.

* Member, Illinois State Medical Society.

F

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young adult, an inpatient
program with provisions for
after-care*



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hospital

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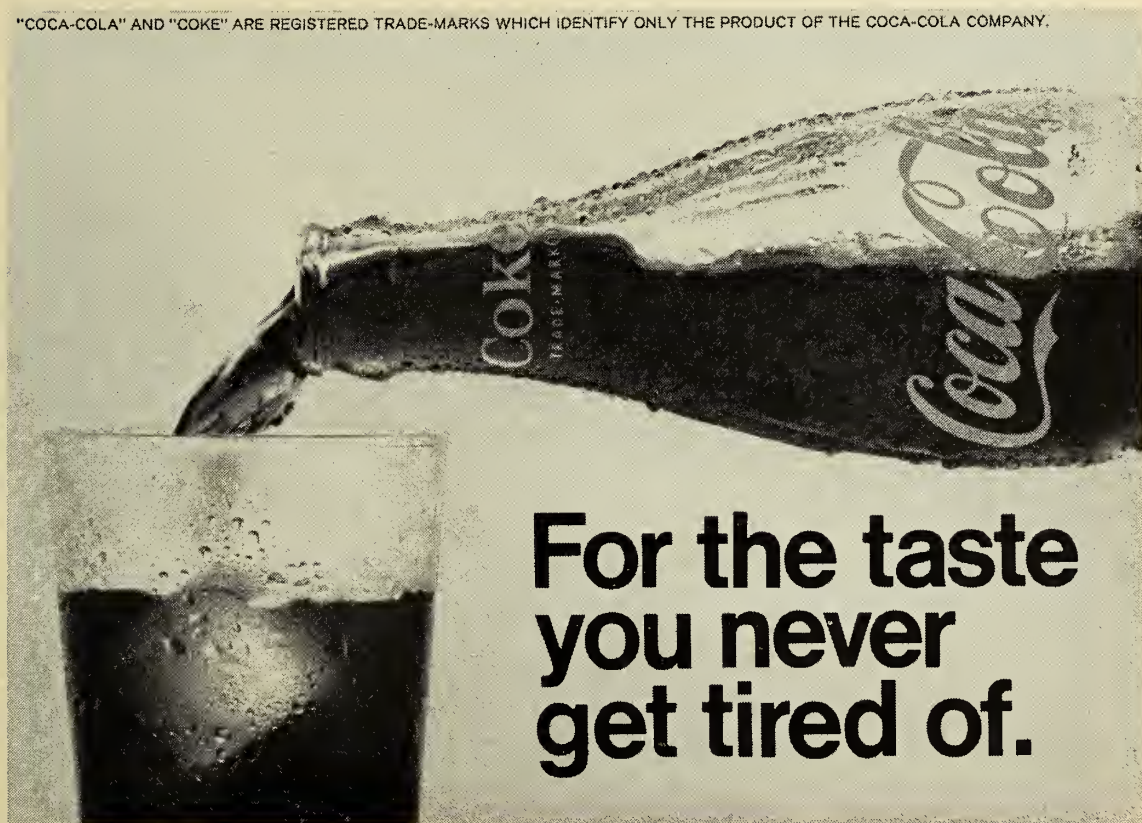
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 SPECIALTY REVIEW COURSE IN PEDIATRICS, May 1
 SPECIALTY REVIEW COURSE IN OB-GYN, May 8
 SPECIALTY REVIEW COURSE IN DERMATOLOGY, May 15
 SPECIALTY REVIEW COURSE IN MEDICINE, Part II, June 5
 PATHOLOGY REVIEW COURSES FOR SPECIALTIES, Request Dates
 PROCTOSCOPY & VARICOSE VEINS, One Week, May 8
 SURGERY OF THE HAND, One Week, May 8
 ADVANCES IN SURGERY, One Week, May 1
 GENERAL SURGERY, One Week, May 1
 BLOOD VESSEL SURGERY, One Week, May 15
 ESOPHAGEAL SURGERY, Three Days, April 26
 VAGINAL APPROACH TO PELVIC SURGERY, One Week, April 24
 FLUIDS & ELECTROLYTES, One Week, April 17
 CLINICAL NEUROLOGY, One Week, April 17
 ADVANCES IN MEDICINE, One Week, May 15
 ANESTHESIA, Inhalation, Endotracheal, Regional, Request Dates

*Information concerning numerous other
 continuation courses available upon request.*

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Doctor's Library

(Continued from page 602)

to orthopedic surgeons. However, there is a variety of information that should attract the attention of those interested in traumatic problems. It should be considered excellent collateral reading for residents in training.

John M. Beal, M.D.

TRAUMATIC CERVICAL SYNDROME AND WHIPLASH. C. W. Goff, J. O. Alden, and J. H. Aldes. J. B. Lippincott Company, Philadelphia, 1964.

The authors have produced a remarkably concise monograph on neck injuries, having a total of 114 pages of text.

The book begins with a discussion of the semantics involved in traumatic cervical syndrome and whiplash and indicates that these terms are used with full realization of their drawbacks.

The frequency of cervical injuries is discussed in Chapter 1. An analysis of the incidence in hospitals is correlated with the findings of insurance agencies. It is apparent that cervical syndromes have become a significant cause of disability throughout the country.

The second chapter deals with the acute traumatic cervical syndrome and discusses separately the problem in children and in adults.

The third chapter deals with the more serious problems of dislocations and fractures, while the next section is concerned with the chronic problems related to the neck. A concise discussion of the treatment, both operative and conservative, follows. The differential diagnosis is considered succinctly.

One chapter deals with pertinent aspects of anatomy, and another with clinical and experimental physiology and pathology.

The final chapter is concerned with disability determinations. There is an appendix devoted to post-traumatic neurosis. A satisfactory list of references is provided.

The majority of illustrations are line drawings which have been carefully selected and illustrate the text in a satisfactory manner.

The book is easily read and provides a capsule survey of neck injuries. The book should be of interest to anyone who is interested in the problems associated with trauma.

John M. Beal, M.D.

PLAN A

Springtime Visit TO DEARBORN

Spring is always a delightful time to come to Dearborn and *The Dearborn Inn*. You'll want to discover America's past at Henry Ford Museum and Greenfield Village just next door, or take a Ford Plant Tour. Or, a 20-minute drive to downtown Detroit's new look, a few minutes more to Canada by bridge or tunnel.

You'll like, too, the country-quiet setting of *The Dearborn Inn*, where hospitality and good food have long been a tradition. Two restaurants, Golden Eagle Cocktail Lounge, ample free parking. May we send our brochure?



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special formula for a special problem

*specifically formulated
for symptomatic
relief of sinus headache*

Sinus headache is not a single entity,
but a chain reaction of pain.
It is facial pain—deep, dull, aching and
nonpulsating. It is referred pain—
originating in the nose and sinuses but
felt at another site. It may become
generalized pain and tension in head and
neck. It is one or all of these.

The Sinutab formula is designed
for symptomatic relief of sinus headache.

It provides two analgesics to relieve
pain and discomfort...an effective oral
decongestant to reduce mucosal congestion...
and an antihistamine to help
control allergic manifestations.

Side Effects: Epigastric distress, drowsi-
ness, dizziness, insomnia and nervousness.

Precautions: Instruct patients not to drive
or operate machinery if drowsiness occurs.

Use with caution in patients with thyroid
disease, heart disease, hypertension, diabetes
or kidney disease. Excessive dosage or
prolonged use may cause kidney damage.

Dosage: Adults—2 tablets every 4 hours.

WARNER-CHILCOTT
Morris Plains, N.J.



SINUTAB[®]

for sinus headache

Each tablet contains
150 mg. acetaminophen,
150 mg. phenacetin,
25 mg. phenylpropanolamine HCl,
and 22 mg. phenyltoloxamine
citrate.

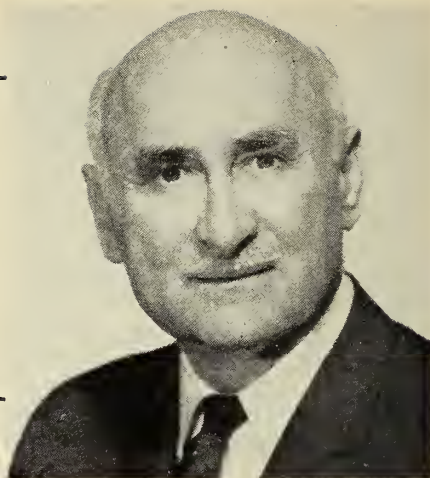
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**Sinus
sphenoidalis**

**Os
occipitale**

The president's page



Caesar Portes, M.D.

Problems of the Medical Society

It is almost a year since I have accepted the very great honor which you have bestowed upon me. I pledged to you at that time my best efforts and to give of myself towards improvements and betterment of the society and medicine. I also asked your support and your advice. Let me assure you that I have received this from you and for which I am very grateful.

I hope that my efforts for the benefit of medicine and the welfare of the people of the State of Illinois and for the Illinois State Medical Society have been fruitful and not in vain. There have been many problems that cannot be solved in a short time, but at least direction has been towards these problems, pointing them out to the medical profession and to the lay people and asking for a solution.

In retrospect, as I look over the past year, I feel a sense of accomplishment and fulfillment. At first it seemed a severe and difficult undertaking. But now, as I look back, it has been a very joyous and pleasant undertaking. I appreciate the great support I received from all of you, from the Board of Trustees, from the other officers, from the office staff, the personnel. Everybody has been of great help and assistance.

This has been a year which I will never forget. It is an experience that is afforded a few once in a lifetime. I will cherish this honor. I will remember this past year. It has been a happy and memorable occasion.

I wish to congratulate my successor. I offer him my assistance and whatever advice I can give. I am sure that he too is

faced with this tremendous mental anxiety, as you might say, because to him too this seems insurmountable. But let me assure my successor that he is capable and I am sure will be able to overcome many of these problems and some of the obstacles that will confront him. I wish him success, good luck, and I hope and pray that the Lord will give him good health, good strength so that he will serve the society in good fashion and that we as humans and doctors of medicine will gain by his efforts and counsel.

As my term of office as your President is coming to a close, I wish I could say that there are no more problems for the medical society. However, as you and I know, there will be many more problems which will confront us as practicing physicians.

I would like to take up one problem which concerns me a great deal and that is the lack of interest of the physician in the affairs of medicine. The attendance at the meetings continues to decrease. The apathy of the doctor towards organized medicine, and the old feeling of "let George do it" is still the feeling of most of my colleagues. As you and I know, the society officers can do only so much without the backing of the membership. The society needs your support now as it has never needed it before.

I had the occasion to speak at a county medical society not long ago. I presented the problems which confront organized medicine. I have also made the statement that I have done as much as I possibly

(Continued on page 745)

Blood Alcohol Levels in Vehicular and Pedestrian Fatalities in Illinois

By JULIUS M. KOWALSKI, M.D., NORMAN J. ROSE, M.D.,
AND FRANK F. FIORESE, PH.D.

In 1965, the Illinois State Legislature authorized a one year Joint Blood Alcohol Study. It was sponsored by the Illinois Department of Public Health, Illinois State Medical Society, the Governor's Official Traffic Safety Coordinating Committee, and the Illinois Coroners' Association. The study encompassed a population in excess of 10,000,000 for the calendar year 1966.

The primary purpose of the study was to determine Blood Alcohol Levels (BAL) in motor vehicular fatalities among drivers, suspected drivers, occupants, and pedestrians. Victims under 15 years of age, either as occupants or pedestrians, were presumed not to have been drinking and were excluded from the study.

The Coroners' Act was amended for the year 1966, placing the responsibility upon

the county coroners for drawing and submitting blood specimens from each traffic accident victim as defined above who died within 24 hours following the accident and prior to any embalming procedures.

Materials And Methods

Because difficulties were encountered in collecting blood specimens by pathologists, coroners and embalmers, three different types of equipment were developed. The preferred method of collecting blood specimens was by cut down over the femoral vein in the groin. The area was prepped with Zerconium Chloride swab prior to cut down.

A #8 soft disposable rubber catheter, with tip cut at a 45 degree angle, was inserted into the vein, attempting to place its tip in the iliac pool. A 35 cc disposable plastic catheter tipped syringe was used to aspirate the sample. The sample was then injected into one or more 15 cc. vacuum or 15 cc. cork stoppered tubes, each containing 45 milligrams of potassium oxalate as an anti-coagulant, and 56 milligrams of sodium flouride as a preservative.

If a fatality occurred in Cook County, the blood specimens were sent to the Cook County Morgue Toxicology Laboratory in

Dr. Kowalski, a Princeton physician, is chairman of the Illinois State Medical Society's Committee on Public Safety; Dr. Rose is chief of the Bureau of Epidemiology in the Illinois Department of Public Health's Division of Preventive Medicine, and Dr. Fiorese is chief of the department's Bureau of Toxicology in the Division of Laboratories. Other members of the ISMS Public Safety Committee who contributed to this study are Clarence E. Cawvey, M.D., James P. Campbell, M.D., George H. Irwin, M.D., Edwin A. Lee, M.D., and Clifford P. Sullivan, M.D.

Chicago. All other specimens were sent to the Illinois Department of Public Health Toxicology Laboratory, also in Chicago.

Mailing containers were supplied to all coroners to insure prompt and safe transportation of specimens to laboratories by police relay, mail or express. A report form, see Fig. 1 (lab slip),* was furnished in each mailing container to identify the sample, furnish pertinent accident data and lab results. The blood alcohol analyses were forwarded to the Bureau of Epidemiology of the Illinois Department of Public Health in Springfield for tabulation and evaluation.

The four seasons of the year 1966 presented a large variety of driving hazards over all types of terrain from flat lands to hilly areas, and over all types of roads from dirt to high speed limited access highways. Every fatality, whether from the most populous urban to remote rural areas, was investigated by a coroner, state or local police.

Results

The number of fatalities for 1966 numbered 2,206. Eliminated from this group were 187 who survived longer than 24

* Blood carbon monoxide results were reported as percent concentration instead of mg. percent as indicated on the lab slip.

hours. Table #1 is a breakdown of all fatalities. It lists by categories, individuals killed by area as drivers, occupants or pedestrians; 120 specimens were lost to the study by breakage, insufficient amount or the presence of formaldehyde. The over all percentage of victims found to have alcohol was 642 (41 percent) Fig. 2. Drivers of all age groups—413—(44 percent), Fig. 2, had measurable BALs.

Of those over age 20, it was found the greatest number of fatalities with measurable BALs were in the 21-29 age group, a total of 251. However, 50 percent of those killed with BALs in excess of 0.10 percent were in the 25-39 year group.

An unusual and pathetic finding was in the young drivers comprising mostly teenagers from 15-20 year olds. Of this group 47 (33 percent), Fig. 3, had measurable BALs. More surprising, approximately one half of this group had BALs over 0.15 percent, Fig. 4.

Among these young victims as occupants, 36 (38 percent), Fig. 3, had measurable BALs and 11 (12 percent) exceeded 0.15 percent, Fig. 4. These fatalities occurred despite the fact that under Illinois laws, it is illegal to sell, procure or serve alcoholic beverages to persons under 21 years of age. Further, these young victims, drivers

LABORATORY REPORT:

BLOOD ALCOHOL _____ mg%

BLOOD CARBON MONOXIDE _____ mg%

DRUGS _____ (SPECIFY)

JOINT BLOOD ALCOHOL STUDY*

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF LABORATORIES
BUREAU OF TOXICOLOGY

NAME _____					
ADDRESS _____					
AGE _____	SEX 1. <input type="checkbox"/> MALE 2. <input type="checkbox"/> FEMALE	RACE 1. <input type="checkbox"/> WHITE 2. <input type="checkbox"/> NEGRO 3. <input type="checkbox"/> OTHER			
OCCUPATION _____		CODE _____	HOUR _____	MONTH _____	DAY _____
VENEPUNCTURE SITE _____		YEAR _____			
TIME AND DATE OF ACCIDENT.....					
TIME AND DATE OF DEATH					
TIME AND DATE BLOOD DRAWN					
DECEDENT WAS: 1. <input type="checkbox"/> DRIVER 2. <input type="checkbox"/> SUSPECTED DRIVER 3. <input type="checkbox"/> OCCUPANT 4. <input type="checkbox"/> PEDESTRIAN					
COUNTY OF)- ACCIDENT		<p style="text-align: center;">MAIL TO:</p> <p>STATE OF ILLINOIS DEPARTMENT OF PUBLIC HEALTH DIVISION OF LABORATORIES BUREAU OF TOXICOLOGY 1800 WEST FILLMORE STREET CHICAGO, ILLINOIS 60612</p>			
OCCURRENCE)- DEATH					
COUNTY CORONER _____					
ADDRESS _____					

* GOVERNOR'S OFFICIAL TRAFFIC SAFETY COORD. COMM. ILLINOIS CORONERS' ASSOCIATION
ILLINOIS STATE MEDICAL SOCIETY ILLINOIS DEPARTMENT OF PUBLIC HEALTH

WRITE FIRMLY WITH BALL POINT PEN
OR USE TYPEWRITER

and occupants, were dispersed almost equally throughout the state.

In the over 20 year age group occupants, only 133 (34 percent), Fig. 2, had measurable BALs. This in contrast to the 15-20 year group occupants who had 38 percent. Among all pedestrian fatalities 83 (40 percent), Fig. 2, had measurable BALs. The pedestrian age group 50-65 showed the highest percentage, 46, with BALs over 0.10 percent.

Summary in conclusions

Blood specimens were collected from individuals killed by or in a vehicle during the calendar year 1966, and encompassed a population in excess of 10 million. Those under 15 years of age were excluded.

A simple, workable method of obtaining the blood specimens is described and is particularly applicable for quasi-professional personnel.

Of 2,206 fatalities, 1,562 blood specimens (75 percent of all victims, with certain exceptions) were submitted for alcohol deter-

minations, with these findings—41 percent (642) showed measurable blood alcohol levels; 25 percent of drivers had levels over 0.15 percent, and 10 percent had BALs from 0.10 percent to 0.15 percent.

In the 15-20 year-old driver group, 33 percent had measurable BALs, of which almost 20 percent had over 0.10 percent; 15 percent had over 0.15 percent.

Approximately 42 percent of the pedestrians had measurable amounts of alcohol, of which 32 percent contained over 0.10 percent BALs.

This study shows the probable relationship between blood alcohol levels of over 0.10 percent and motor vehicle fatalities. The number killed with appreciable amounts of alcohol in their blood seems to indicate that the legal limit for "driving while under the influence" should be not more than 0.10 percent. Education and enforcement of existing laws might reduce fatalities in the under 21-year-old age group.

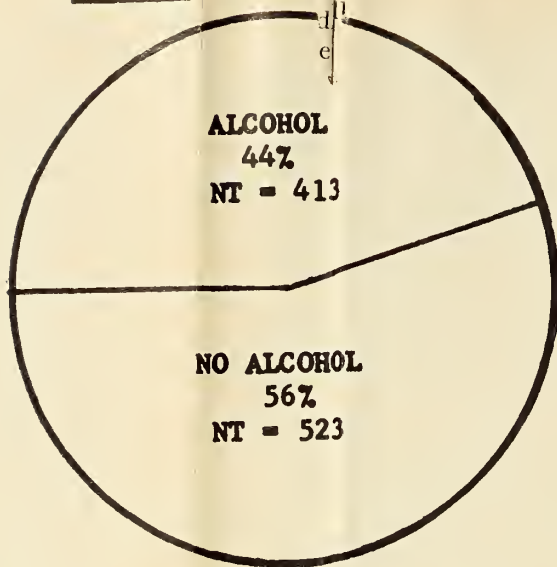
Table I
Joint Blood Alcohol Study
Jan. 1, 1966, Thru Dec. 31, 1966

Number of Fatalities Reported		Positives Specimens	642
By Division of Highways	2,206	Alcohol	642
Downstate Fatalities	1,678	Carbon Monoxide	56
Cook County Fatalities	528	Carbon & Alcohol	51
Number Who Lived Longer Than		Carbon & Amphetamine	2
24 Hours Excluded	187	Amphetamine	9
Downstate Survivors	141	Barbiturate	9
Cook County Survivors	46	Other	6
Total Number Acceptable		Negative Specimens	800
For This Study	2,019	Unsatisfactory Specimens	120
Downstate Fatalities	1,537	Formaldehyde	53
Cook County Fatalities	482	Broken	26
Number of Blood Specimens		Insufficient	41
Examined And Reported		Breakdown By Classification	
To This Office	1,562	Downstate	1,195
Downstate	1,195	Driver	747
Vehicular	1,068	Occupant	321
Pedestrian	99	Pedestrian	99
Not Stated	28	Not Stated	28
Cook County	367	Cook County	367
Vehicular	255	Driver	189
Pedestrian	107	Occupant	66
Not Stated	5	Pedestrian	107
Reporting Percentages:		Not Stated	5
Downstate	78%		
Cook County	76%		

JOINT BLOOD ALCOHOL STUDY

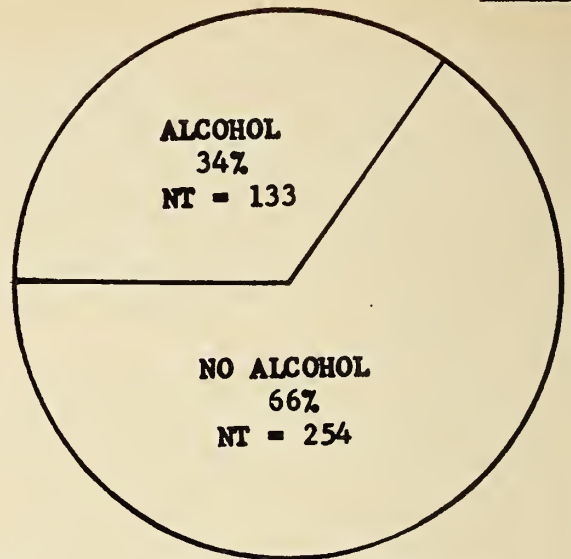
STATE ALCOHOL ANALYSIS
JANUARY 1, 1966 - DECEMBER 31, 1966

DRIVERS



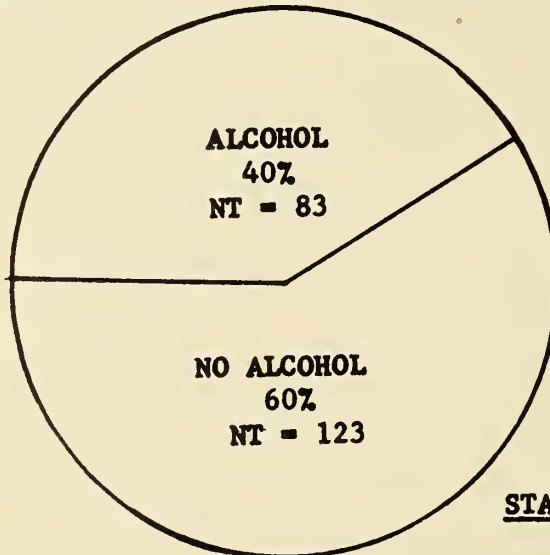
No. Tested = 936

OCCUPANT



No. Tested = 387

PEDESTRIANS



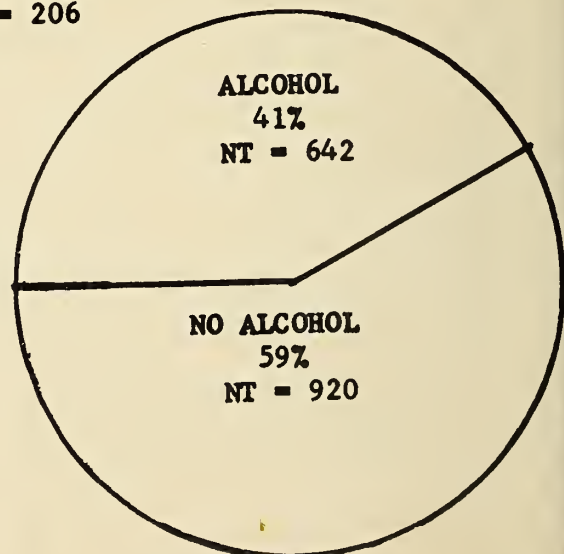
No. Tested = 206

CLASSIFICATION UNKNOWN



No. Tested = 33

STATEWIDE - ALL CLASSIFICATIONS



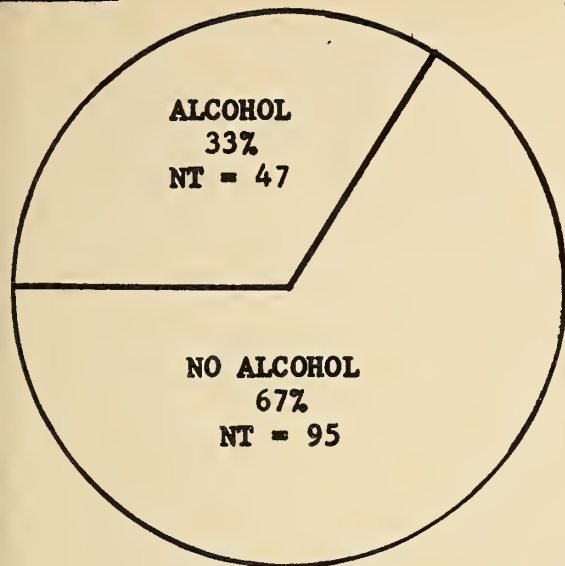
Total No. Tested = 1,562

Fig. 2

JOINT BLOOD ALCOHOL STUDY

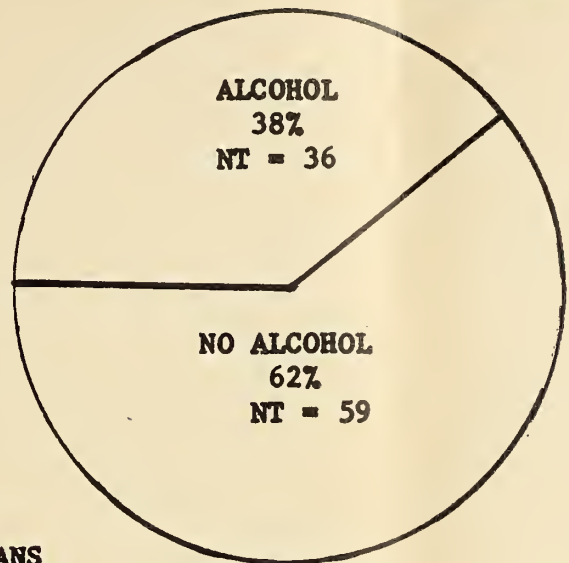
STATE ALCOHOL ANALYSIS
JANUARY 1, 1966 - DECEMBER 31, 1966
15-20 AGE GROUP

DRIVERS



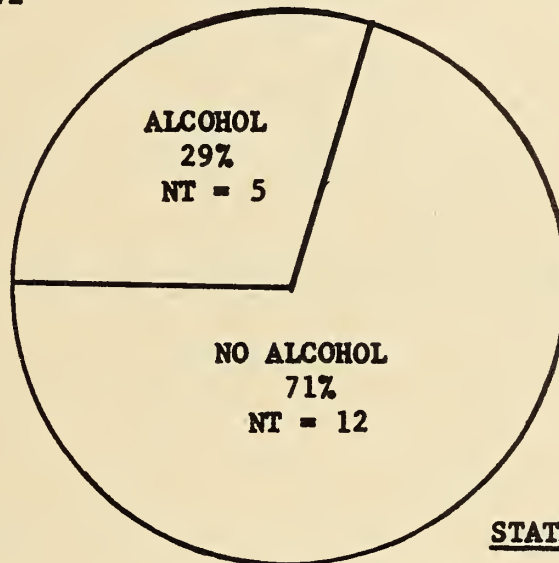
No. Tested = 142

OCCUPANTS



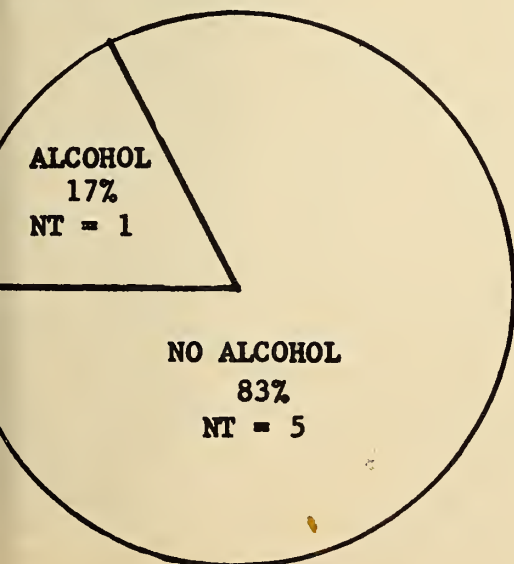
No. Tested = 95

PEDESTRIANS



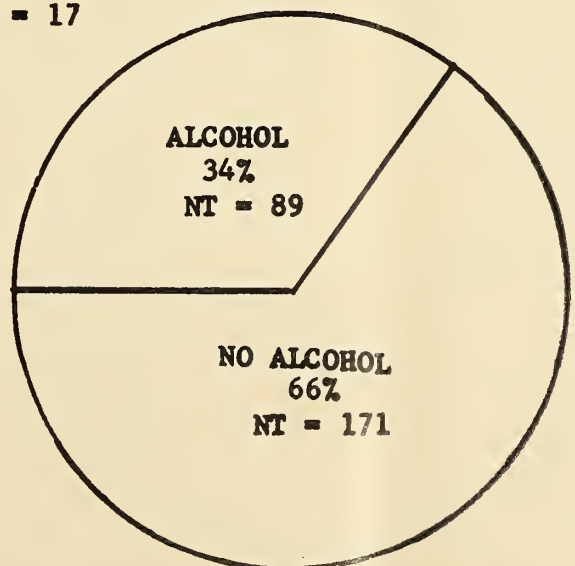
No. Tested = 17

CLASSIFICATION UNKNOWN



No. Tested = 6

STATEWIDE - ALL CLASSIFICATIONS



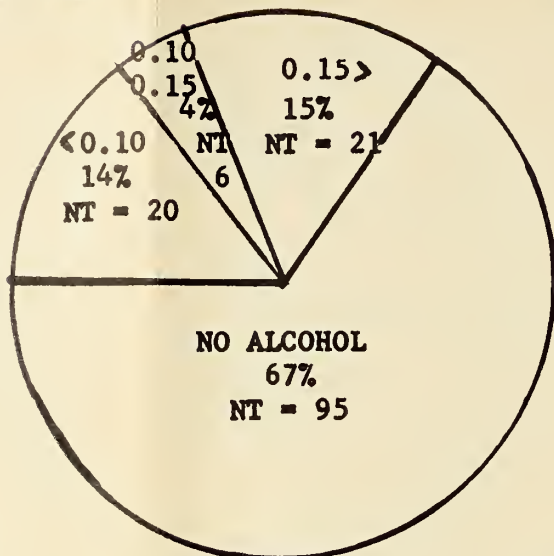
Total No. Tested = 260

Fig. 3

JOINT BLOOD ALCOHOL STUDY

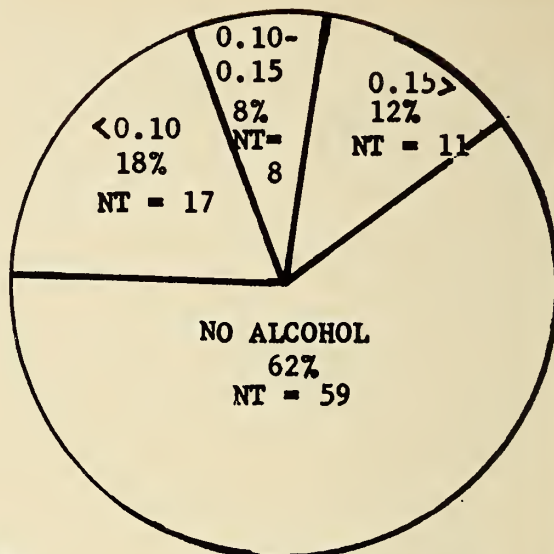
BREAKDOWN BY GMS. % OF ALCOHOL
JANUARY 1, 1966 - DECEMBER 31, 1966
15-20 AGE GROUP

DRIVERS



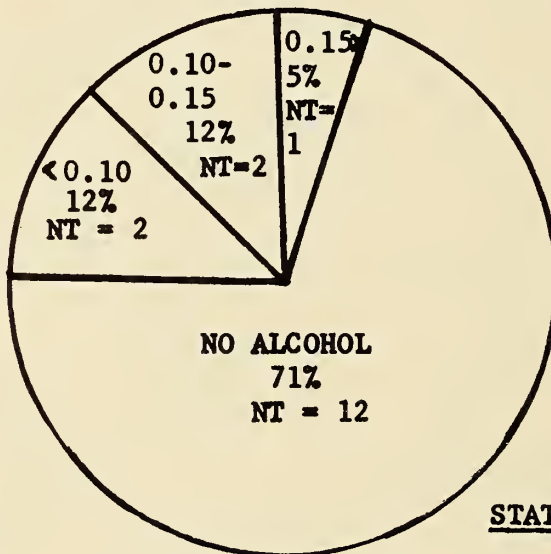
No. Tested = 142

OCCUPANTS



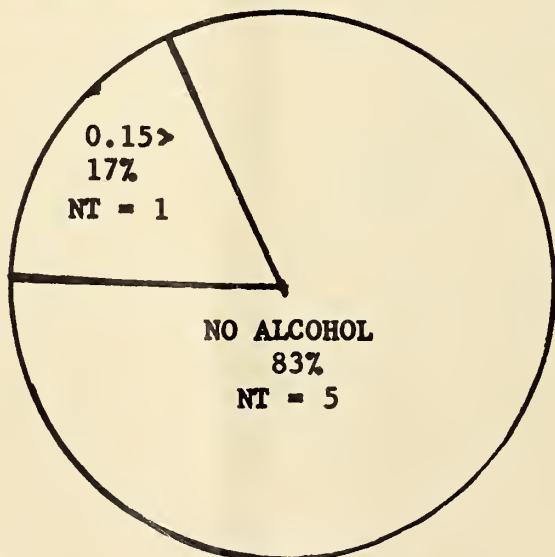
No. Tested = 95

PEDESTRIANS



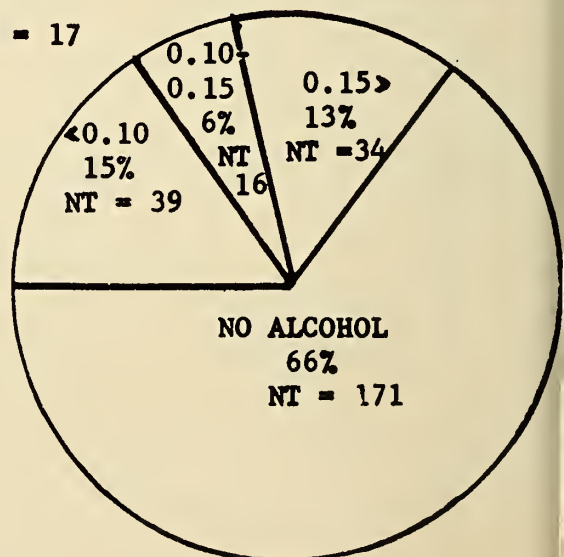
No. Tested = 17

CLASSIFICATION UNKNOWN



No. Tested = 6

STATEWIDE - ALL CLASSIFICATIONS



Total No. Tested = 260

Fig. 4

Ocular Aspects of Vertigo

By JOSEPH E. ALFANO, M.D./GARY, IND.

Vertigo in its severest manifestation is rarely of ocular origin. It is usually due to disease of the labyrinth, brain (particularly the brain stem or cerebellum), or of the circulatory system.

Vertigo in its mild, moderate, or in rare cases in its severest degree may be of ocular origin. Ocular causes for vertigo include (1) the ordering or changing of spectacle lenses, (2) ocular muscle imbalance, (3) nystagmus, (4) ocular medications, and (5) certain acute intra-ocular disorders.

The ordering of spectacle lenses for the first time or the correction of anisometropia for the first time may lead to the production of a vertigo or a feeling of giddiness, light headedness or unsteadiness. The ordering of the aphakic correction following cataract surgery is particularly significant in this regard.

Vertigo may occur in the early stages of an accommodative esotropia or exotropia.

The sudden onset of a paralytic strabismus particularly one of the oblique muscles (cyclotropia) may produce a sensation of confusion or vertigo.

Any nystagmus particularly the sudden onset of a vestibular nystagmus is usually associated with a sudden onset of a severe vertigo.

The instillation of either a mydriatic or a miotic drug particularly unilaterally frequently produces a sensation of vertigo, giddiness or confusion.

The sudden onset of certain unilateral ocular diseases may give rise to the sensation of dizziness or confusion. These conditions include the unilateral subluxation of the lens or an acute detachment of the retina or the sudden onset of a macular hemorrhage or a macular edema.

Any patient with ocular vertigo requires a complete medical and neurological as well as ophthalmological surgery.

Vertigo From A Neurosurgical Viewpoint

By NICHOLAS WETZEL, M.D., PH.D./CHICAGO

The symptom of vertigo, or dizziness, is frequently encountered in neurologic and neurologic practice. However, care must be taken through careful questioning to be sure that the patient has true vertigo rather than other neurological disturbance, such as loss of position sense or ataxia. Further careful history taking will be of great value in planning the diagnostic work-up and subsequent treatment.

Vertigo may result from head injuries with or without fracture of the skull. A distressing persistence of symptoms after a seemingly minor injury, with or without objective findings, is not at all unusual. Many patients seek neurosurgical advice

because of fear that their symptoms of vertigo are on the basis of a space occupying lesion. Cerebral abscesses are now infrequent, but other tumors within the skull may produce vertigo. Tumors of the posterior fossa may have an incidence of vertigo, tinnitus, and hearing loss of 80 percent, and various statistics report 25 to 50 percent of all intracranial tumors as having some similar symptoms. Dizziness may also arise from vascular disease, whether due to arteriosclerotic obstruction of the carotids or vertebral arteries, or may be due to extravascular factors, such as impingement upon the vertebral artery by osteophytes, the so-called Barre-Lieou syndrome, or by fibres or muscular bands in the neck. An irritable carotid sinus may also cause frequent episodes of vertigo and can be surgically treated.

Dr. Wetzel is a member of the department of surgery at Northwestern University Medical School.

Medical Implications of the

By ROBERT R. HARTMAN, M.D.
*Chairman, Illinois State Medical Society
Committee on Maternal Welfare*

May I welcome you, on behalf of the ISMS to what we believe will be a unique symposium on the "Medical Implications of the Current Abortion Law in Illinois." To the best of our knowledge no medical society has heretofore sponsored a public forum at which a panel composed entirely of physicians has discussed the law by which their conduct is circumscribed.

While your moderator was not a participant in the deliberations leading to the decision to sponsor such a hearing, he finds himself in total agreement with the wisdom of that conclusion.

Interest in the subject of abortion probably dates back to man's comprehension of the fundamental facts of reproduction. Certainly since Biblical times rules have been promulgated regarding the performance of abortion. These laws have been influenced by ethical, moral, social, yes, even economic considerations. The more recent availability of data regarding fetal physiology, genetics, teratogenesis, indeed even interpersonal relationships has exerted a modifying influence upon our attitudes in this regard. The lay press has seen a spate of articles regarding the need to maintain or ameliorate conditions under which abortion should be licit. Several legislatures have been or are currently considering changing the abortion laws, and the cry of various pressure groups has been loud if not clear.

Physician's Right To Discuss

By what right do we as physicians meet to discuss this problem? There are those who charge that attorneys do not write the laws nor attempt to enforce them and conclude therefore that the physician "is merely a technical expert; no more qualified than any other layman to pronounce on the rights or legality of such acts, let alone

to determine what these rights should be, relying merely on the whims and dictates of his conscience. The decision on whether a human life, once conceived, is to be or not to be, therefore, properly belongs to moral experts or to the legislatures guided by such experts."

We as physicians are apt to regard this argument as spurious, since if it is our task to fit our actions to the law, we should be able to request modification of the law if it fails to fit the needs of the patient. If the law is appropriate, no modification is needed; if it is in need of revision, we should be able to recite our experiences that indicate the need for change. As medicine is not static, so the law should be fluid and not unchanging. Are not moral principles the distillation of wisdom as influenced by experience? If so, may not the accumulation of new knowledge and experience call for a modification or new interpretation of the principle?

Suitability of Physician's Counsel

We physicians feel that if we are to be called upon to adjudicate these crucial matters of life and death, we must perforce help to determine and delineate the acceptable indications.

The current Illinois statute makes the performance of an abortion a crime punishable by imprisonment but states "it shall be an affirmative defense that the abortion was performed . . . because necessary for the preservation of the woman's life."

If it is logical for the physician to determine the circumstances that may threaten a woman's life, is it not logical that the decisions regarding the infant's life should be in similar hands. By what right do philosophers, legislators, or even moralists derogate the physician to the role of the technician?

Current Abortion Law in Illinois

By EDWIN DeCOSTA, M.D., (LIBERAL) OBSTETRICS

*Professor of Obstetrics and Gynecology, Northwestern University Medical School;
Attending Obstetrician and Gynecologist, Passavant Memorial Hospital, Chicago*

From the attitudes of the panel participants in today's symposium should come further evidence of the suitability of the physician's counsel in defining the terms under which these awesome decisions are to be made.

Authorities from Four Fields

Our panelists have been selected with care; and while these proceedings are not to be in the form of a debate, each participant has been charged with the task of presenting his views, as modified by his particular field of special interest, relative to modifying or maintaining the law only as these views are influenced by medical implications. This, admittedly, may be difficult, as moral and ethical shadows may becloud these opinions; but I am confident that we shall hear forthright, disciplined, and cogent arguments, free of prejudice, for and against change. We have called our authorities from four fields of medical practice most apt to be concerned with these awesome decisions: obstetrics, pediatrics, psychiatry, and public health.

Station WFLD, Chicago, taped proceedings of the Illinois State Medical Society's Symposium on the Medical Implications of Illinois' Abortion Law, and presented highlights of the conference March 15 on Channel 32. The WFLD program was called "Abortion: Old Laws—New Problems."

At the end of the show viewers were asked to send their opinions on a number of specific questions dealing with the medical aspects of the program. A complete tabulation of these responses was prepared by the Communicators Research Center of Chicago and appears on pages 693-695. Highlights of total responses to the questions are shown in graph form beginning on page 684.

I want to express my pleasure at the opportunity of being here. Also, I want to express my pleasure at being the lead-off man on the program. I am sure that many of the things I must say will be encroaching upon the provinces of my good friends who follow me. If one must engage in a controversial subject, it's nice to get to bat first.

At this juncture I want to emphasize that this symposium is solely concerned with the pros and cons for changing the existing laws which relate to therapeutic abortion in the State of Illinois. There is no intent to delve into the subject of criminal abortion and its associated problems. Here, I emphasize, we are interested only in legal abortion for medical reasons. Nor will it be our purpose to consider the validity of accepted indications, nor to suggest the addition of new ones. We are interested in whether or not it is advisable to amend or rewrite the existing statutes, particularly in the light of present day practice.

Obstetrical Indications

My subject is obstetrics, and I assume that I am expected to discuss the obstetrical indications for therapeutic abortion. I must overflow somewhat into the realm of pediatrics, psychiatry and internal medicine because the guidelines are not that well defined.

Strictly speaking, and from the viewpoint of both obstetrical and medical indications, there are few reasons today to perform therapeutic abortion. For example, hyperemesis gravidarum once was a real indication. Today, with good prenatal care, hyperemesis gravidarum rarely occurs.

Then there are several diseases incidental to pregnancy for which occasionally there may be reason to empty the uterus before the period of viability. In this group are

severe toxemia, placental abnormalities (previa and abruptio), and hydramnios, which might jeopardize the woman's life unless the pregnancy is terminated.

Concomitant Conditions

We also have a variety of other conditions, both medical and psychiatric, which appear to be aggravated by concomitant pregnancy, or which cannot be treated without damaging or interrupting the pregnancy. Those conditions which are aggravated by pregnancy include tuberculosis, heart disease, kidney disease and chronic hypertensive vascular disease. Those conditions in which therapy will destroy the fetus include malignancy of the genital organs or elsewhere in the body, and ectopic pregnancy. No one would consider not treating cancer just because the woman is pregnant. Likewise, no one would permit the mother with a tubal pregnancy to bleed to death in the vain hope of trying to maintain such a pregnancy.

Thus we observe that as medical knowledge has advanced, there are actually fewer reasons for therapeutic abortion than there were thirty years ago. During the pre-insulin era diabetes was reason for abortion. Today, we treat the diabetes and permit the pregnancy to continue. The same goes for other medical indications. Heart disease is treated as heart disease, and tuberculosis as tuberculosis. One of the few remaining medical indications is severe kidney damage associated with vascular changes or with calculi.

German Measles

If we add up all the indications for therapeutic abortions—and that includes those for psychiatric reasons and those in which the fetus is apt to be severely damaged, as, for example, following German measles—there are probably not over 8,000 performed each year in the entire United States. Of these, *over half are for psychiatric reasons and for German measles.*

Why then, all the concern? Why this gathering? Is it over the question of whether it is proper to perform a few abortions, more or less? Of course not. The issues are much greater than numerical numbers.

As you all know, the law of the land, specifically that of the State of Illinois, permits abortion for *one reason* only, namely, for the preservation of the woman's life.

This law has remained upon the books without basic change for 100 years.

Law Is Violated

I have just told you that over half of all indications given for therapeutic abortions as undertaken today are *not* to save the life of the mother, but rather to try to *preserve her health* or to prevent the birth of a presumably severely damaged child. In plain English, this means that even though the law *is not enforced*, it is violated. I abhor lawlessness, and believe that the law should be brought into line with practice, and that physicians should not be forced to violate a law in order to pursue that which they believe to be proper medicine.

To this end, the Chicago Gynecological Society has recommended that our current statutes be amended to include interruption of pregnancy when not only the life but also the health of the mother are in jeopardy. Such simple modification can be interpreted to cover the recommendations set forth in the Model Penal Code of the American Law Institute in 1959.

Law Institute Recommendations

The Law Institute recommended that therapeutic abortion be permitted:

1. When continuation of a pregnancy would gravely impair the physical or mental health of the mother, or threaten the life of the mother;
2. When pregnancy resulted from rape or incest; and
3. When there was great or significant risk that the child would be born with serious physical or mental defects.

These recommendations are being considered by many state legislative bodies across the country, and during the past month have been endorsed by the Indiana House by a vote of 62 to 13.

Now, there are other reasons too for hoping that the public and in turn their representative, the legislature, will modify the existing statutes. It has long been observed that the number of therapeutic abortions performed in private hospitals greatly exceeds those in public hospitals. In other words, it appears that abortion is the *privilege of the privileged!* This certainly is true with respect to criminal abortion which takes money.

I think the time is at hand when discrimination *should cease* and when a poor, un-

derprivileged woman should have the same rights and receive the same consideration under similar circumstances that are granted the more affluent. Why should the poor woman who has had rubella be forced to carry the pregnancy when her well-to-do sister, under the same conditions, can go to a good hospital and be aborted by a reputable physician?

The answer is simple: No one really cares enough about her to go out on a limb and violate the law! It is easy to refuse her because she does not warrant any personal risk. But—if the law were changed so that there would be no violation, then she might expect and receive the same consideration as anyone else.

Lest we forget, therapeutic abortions are only performed in accredited hospitals by licensed physicians. Most of these hospitals have properly constituted consultation

boards or abortion committees to consider the indications prior to the act. Their recommendations must be followed.

Practice According to Conscience

Those physicians who do *not* wish to perform an abortion, need not; but by the same token, I do not believe that their attitude should dictate the behavior of a colleague who may not share the same outlook. Each man should be permitted to practice medicine in accordance with his own training and conscience. In fact, he is licensed to do just that, in just about every situation, except that pertaining to abortion.

In closing, may I reiterate that the suggested changes in the law would legalize a few thousand more abortions per year in the entire nation, but these changes would remedy a situation which has forced many physicians to violate the law.

By WALTER F. DILLON, M.D., (CONSERVATIVE) OBSTETRICS
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Senior Attending, Mercy Hospital, and Chairman, Department of
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To avoid any misunderstanding, my discussion today will be based purely on my own beliefs, and any agreement or disagreement with the institutions with which I am associated is purely coincidental. I, alone, take full responsibility for my own statements.

Abortion as a means of therapy is either (1) Direct when the sole aim is the elimination of the conceptus from its site of implantation in the uterus, or (2) Indirect when the conceptus is removed as a result of treating a disease process in the site of implantation in the mother. An example of the latter is the removal of a diseased tube with an unruptured tubal pregnancy, or treatment of a pregnant uterus diseased with cancer of the cervix by hysterectomy and node dissection, or by radium and x-ray which causes death of the fetus and eventual abortion coincidental with the destruction of cancer. Indirect abortion thus has a double effect, good in that a disease process is alleviated, and bad in that a fetus is destroyed.

Inalienable Right to be Born

I, personally cannot justify a direct abortion for any reason, as I feel that the *fetus*

has an inalienable right to be born, and the right exists from the time of conception and as established in the 14th amendment of the Constitution, is not to be deprived of life without due process of the law. The question that faces society today, is when does the fetus become entitled to that right? I might raise a similar question by asking when does an individual cease to become protected by that same right? Is it when death occurs, or when the seventh stage of life progresses into a vegetative senility, that is comatose, breathing, and taking nourishment through a tube. I am certain that those who would advocate direct abortion, would not advocate the gas chamber for their elderly parent who had entered a stage of vegetative senility. If we show respect for the latter, why can we not show a similar respect for the unborn fetus? The fetus has not reached its stage of usefulness, and the senile patient has passed his.

Until the time that scientific man can create life out of the bare elements, he should not be given the opportunity to destroy it at will. In the interim, the laws pertaining to abortion should be enforced. If the present law is bad, it should be

changed and enforced. However any change in the law should protect the fetus, the mother, and society.

Gynecological Society Resolution

Perusal of the present law, Chapter 28, Article 23 of the Criminal Law and Procedure does not permit abortion but it states that "it shall be an affirmative defense to abortion, that the abortion was performed by a physician licensed to practice medicine and surgery in all its branches in a licensed hospital or other licensed facility because necessary for preservation of the woman's life." Medical schools, hospitals, and ethical physicians have not been penalized by the law in its present form. However, I can see where they might be worried lest they be called upon to defend their actions. The resolution passed by the Chicago Gynecological Society in 1966 sets up more rigid restrictions as to where an abortion may be done, but the when and why would be left up to a committee composed of variables that would fluctuate with the times and institutions. The additional suggestion that therapeutic abortion be reported to the state was not passed. However hospitals with obstetric sections must be approved by the state or its agency. The foregoing resolution while it is seemingly more protective takes away from the state the right to give the fetus or human being, due process of the law; and is probably also in conflict with the State Licensing Act which gives a licensed physician permission to practice medicine in all its branches.

Added Strain of Pregnancy

So much for the Law. Let us discuss why abortions are being done. Pregnancy is a strain upon the normal individual, but to which she is capable of making proper adjustment just as the prime athlete is capable of making adjustment to the feats of his skill. However in certain disease processes the added strain of pregnancy, household duties, inadequate nutrition, inadequate rest, or surgical procedures such as therapeutic abortions may prove to be the "straw that breaks the camel's back." Medical diseases must be treated 24 hours a day, and all days of the patient's life, and not only during the pregnant state. Occasionally the patient receives excellent care only while pregnant. The pregnant patient with

advanced heart disease may be better off at complete bed rest in a hospital than when she returns home to a third floor walkup, and all the other turmoils to which a mother may be exposed. She may look back upon her pregnancy as a period of restful tranquility. There is no question that pregnancy places a severe strain on the severe cardiac, or later on the mild cardiac during the raising of the family, and also upon the hypertensive and nephritic patients. Consequently these patients should not get pregnant. However when they do, with proper care they can be safely carried to normal delivery, or spontaneous delivery of a stillborn.

Heart Disease and Nephritis

Heart disease patients must have their reserve protected through life. Once they become pregnant, this may mean complete bed rest until the pregnancy is terminated, and the physiologic changes brought about by the pregnancy have returned to normal. This latter phenomenon does not necessarily occur on the fifth postpartum day or at the six-week visit to the physician. Delivery of the cardiac patient is by the normal method as it is felt that it is less traumatic than the surgical approach. Deaths will continue to occur from cardiac causes, in male and female and whether the pregnancy is present in the female or not.

Nephritis in itself is a serious disease. The average life expectancy in the chronic nephritic without edema is 14 years. Pregnancy places an additional strain on the patient, and pregnancy is best avoided. If the disease is mild, and the patient protected, the mother and child may be safely carried through the period of strain. If the disease is severe, with proper care that usually means complete bed rest, she can be safely carried to the point where fetal death occurs in seventh or eighth month and the patient spontaneously delivers without surgical trauma. Admittedly the strain on the mother varies directly as the duration of the pregnancy.

Kidney Infections and Tuberculosis

Chronic kidney infections, or conditions interfering with kidney drainage can be effectively treated with chemotherapy or antibiotics, or surgical drainage.

Pulmonary tuberculosis that cannot be controlled in the pregnant patient cannot

be controlled in the nonpregnant. Today pregnant tuberculous patients can be rendered non-infective, and surgery can remove the source of potential recurrence.

Since there are psychiatrists upon the panel today, I will not discuss the effect of pregnancy upon the disturbed mental patient other than raise the inquiry, what is the effect of abortion on the disturbed patient and upon the normal patient? If an unwanted pregnancy can trigger an exacerbation of a mental condition, why cannot a violation of a natural maternal instinct also trigger a breakdown? Even in cases of unintentional pregnancy, the average patient accepts her state, and if spontaneous abortion occurs, normally a temporary emotional depression results. Once pregnant, the normal patient wants the pregnancy to go to a successful conclusion, society and her husband's views notwithstanding.

Fetal indications as a cause for therapeutic abortion will be discussed by the pediatricians. However since the obstetrician must perform the act, I wish to state that it is a form of obstetrical Russian Roulette. How can this be justified when the majority of these fetuses are normal? In cases of rubella during the first three months of pregnancy, two out of three of these are normal. Must modern society relive history and surpass Herod by invading the uterus looking for disease? Again just when does the fetus deserve the right of protection from society. Recently the Wisconsin State Supreme Court ruled in favor of a fetus killed in the last months of pregnancy. At what second does the fetus become eligible for this protection?

20-Year Review of Abortions

In an excellent review of therapeutic abortions in New York over a 20-year period, Gold and Associates review the incidence and the indications. He states that there is a consistent downward trend during 1943 to 1962, the decline being in the nature of 65 percent from a ratio of 5.1 to 1.8 per 1,000 live births, the Manhattan rate being higher than the other boroughs. The white ratio of abortion was five times that of the non-white and 26 times that of the Puerto Ricans. From 1951 to 1962 the overall frequency has declined by 50 percent per 1,000 live births, and the frequency of individual indications has declined by 22 to 93 percent suggesting that the natural his-

tory of the disease is not influenced deleteriously by an intercurrent pregnancy, and neither is the pregnancy seriously affected by the medical condition. Comparing the private hospital with the voluntary hospital with a private and ward service, and with a municipal hospital, Gold reports the overall incidence of therapeutic abortion as 41 for the private, 25, and 7.4 for the private and ward cases in the voluntary hospital and only 2.4 for the municipal hospital per 1,000 births. When mental illness was the indication, the incidence was 26 for the private, 14 and 2.6 for the voluntary and only .9 in the municipal. Levity might suggest that only those with money have nervous disorders, or that when a fee is involved the indications are less stringent. The question is thus raised if controls are removed from the state, would indiscriminate abortions occur in some institutions? Concomitant with the decline in therapeutic abortions, the maternal death rate has decreased during these 20 years. However the maternal death rate from criminal abortions has doubled from 1.6 to 3.1 per 10,000 live births during the 20 years and the rate was lower in the white race suggesting that they were better able to seek more skilled talent.

Treatment Following Rape

Concerning cases of rape, there should be no need for therapeutic abortion. Following sexual assault, the victim can be treated by vaginal cleansing and uterine curettage to remove sperm, and given antibiotics to prevent infection from venereal disease, for 48 hours. Unfortunately some cases that were only a memorable experience become rape when pregnancy becomes evident. If the assault is immediately reported, the patient can be hospitalized, pregnancy ruled out by a two hour test, and appropriate therapy instituted. An example of the foregoing is a case that was assaulted in Mexico City and the patient took a plane to Chicago and was treated within 12 hours of the act.

Pregnancy in the unwed no doubt causes nervous moments, but to which the patient makes adequate adjustment. For a number of years I have been in charge of a clinic for unwed girls, and mental disturbances have not been a problem. To remove control of the State from these cases would result in wanton destruction of normal fetuses, as mental trauma would be the in-

dication in some institutions. To facilitate abortion would be to give impetus to lowering of moral standards. While one cannot legislate morality, one can legislate procedures that facilitate immorality.

Causes of Maternal Death

If the therapeutic direct abortion is important to the life of the mother, let us review some of the causes of maternal death. In the State of Illinois 1960-1965 there were from 61 to 71 maternal deaths each year. Referring to Fig. 3 there were only six deaths from hypertensive disease and renal disease in six years. These are diseases that are frequently the indication used for abortion. However during the same period of time deaths from abortion were 11, 19.6, 17, 16, 15 and 16 percent respectively, and an average of only one death a year due to criminal abortion. Most of the deaths were complicated by sepsis. Abortion in itself is not an innocuous procedure whether it is spontaneous or therapeutic. The treatment should not be worse than the disease.

In summary, the State of Illinois has a law forbidding abortions, but states that it would be an affirmative defense to abortion

if such procedure was done by a licensed physician in a licensed hospital because necessary for the preservation of the woman's life. The incidence of therapeutic abortion has decreased through the years concomitant with a decrease in maternal mortality resulting from a better management of the disease processes in ethical institutions. However the desire to include fetal indications as a cause has increased especially on the West Coast despite the evidence that many of these are normal fetuses or have remedial defects. Again my own feeling is that the fetus has an inalienable right to be born, and this right must be protected by the State as guaranteed by the Constitution. The State must never relinquish its authority by granting free license for the performance of abortion.

In closing, I wish to thank the Illinois State Medical Society for bringing this subject forth in open discussion.

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Fig. 1
THERAPEUTIC ABORTIONS IN NEW YORK CITY
1954—62*

Indication	Type of Care			
	Proprietary Hosp.	Pvt. Ser. Vol. Hosp.	Gen. Serv.	Municipal Hosp.
All	41.5	25.5	7.4	2.4
Mental Disorder	26.0	14.3	2.6	0.9
Rheumatic Heart Disease	2.0	1.0	0.8	0.1
Tuberculosis	1.4	0.6	1.4	0.2
Rubella	2.9	2.8	0.1	0.2
Hypertension and Toxemia	1.6	0.8	0.4	0.2
Benign Neoplasms	0.8	0.4	0.2	0.1
Diseases of Nervous System	1.0	0.6	0.5	0.1

*Ratio per 1,000 Live Births

Fig. 2
MATERNAL MORTALITY RATES IN NEW YORK CITY

Ethnic Group	1951—53		1960—62	
	Total	Due to Abortion	Total	Due to Abortion
All Groups	6.3	1.6 (26 percent)	7.3	3.1 (42 percent)
White	4.0	0.6 (14 percent)	4.0	1.0 (25 percent)
Non white	17.0	6.1 (36 percent)	16.2	8.0 (49 percent)
Puerto Rican	9.2	4.0 (44 percent)	8.5	4.7 (56 percent)

Fig. 3a
MATERNAL DEATHS AMONG RESIDENTS OF ILLINOIS BY CAUSE
1960—1965

	1960	1961	1962	1963	1964	1965
All Causes	70	61	70	70	71	60
Complications of Pregnancy	25	20	24	22	23	26
Infections of genito-urinary system	3	—	1	2	2	1
Toxemias	9	10	8	11	10	15
Hypertensive Disease	1	—	1	1	—	—
Renal Disease	1	3	2	—	—	—
Pre-eclampsia	—	1	—	2	1	3
Eclampsia	5	2	4	4	3	4
Other toxemias	2	4	1	4	6	8
Ectopic Pregnancy	6	3	6	5	5	7
Other Complications of Pregnancy	—	2	—	—	1	—
Abortions	8	12	12	11	11	11
Without mention of sepsis or tox.	2	3	1	5	3	6
With sepsis	5	9	11	6	(8)	(3)
With toxemia	1	—	—	—	—	2

Fig. 3b
MATERNAL DEATHS AMONG RESIDENTS OF ILLINOIS BY CAUSE
1960-1965

	1960	1961	1962	1963	1964	1965
All Causes	70	61	70	70	71	69
Delivery without complication	—	2	—	—	1	1
Delivery with specified complication	23	17	22	24	27	17
Placenta Previa or antepartum hemorrhage	7	2	3	3	5	5
Retained Placenta	—	2	2	—	2	1
Other post-partum hemorrhage	4	1	5	6	6	3
Disproportion or malposition	5	2	1	4	2	2
Prolonged labor of other origin	—	—	3	—	3	1
Trauma	3	4	3	7	3	4
Other complications	4	6	6	4	6	1
Complications of the Puerperium	14	10	12	13	9	15
Urinary infection without other sepsis	—	1	—	—	2	2
Sepsis of childbirth and puerp.	4	5	3	5	—	—
Puerperal phlebitis and thrombosis	1	—	1	5	1	4
Puerperal pulmonary embolism	2	2	4	1	2	4
Puerperal eclampsia	1	1	1	—	—	—
Other forms of puerp. toxemia	2	1	—	—	1	—
Cerebral hemorrhage in puerperium	3	—	1	—	1	—
Other and unspecified complications of puerperium	1	—	2	2	2	5

Fig. 4
THERAPEUTIC ABORTIONS IN
NEW YORK CITY
TYPE OF CARE

	Ratio per 1000 Live Births 1951-53	Ratio per 1000 Live Births 1960-62
Proprietary Hospital	6.3	3.9
Pvt. Service Voluntary Hospital	3.6	2.4
Gen. Service Voluntary Hospital	1.9	0.7
Municipal Hospital	1.2	0.1

Fig. 5
THERAPEUTIC ABORTIONS IN
NEW YORK CITY
INDICATION

	Ratio per 1000 Live Births 1951-53	Ratio per 1000 Live Births 1960-62
All	34.8	17.5
Mental Disorders	13.1	10.6
Rheumatic Heart Disease	2.5	0.7
Tuberculosis	3.3	0.7
Rubella	1.2	1.2
Hypertension and Toxemia	2.8	0.6
Benign Neoplasms	3.0	0.2
Disease of Nervous System	1.0	0.3

Fig. 7
THERAPEUTIC ABORTIONS
IN NEW YORK CITY
AGE AND PARITY

	Ratio per 1000 Live Births 1951-53	Ratio per 1000 Live Births 1960-62
Age of Mother		
Under 24	1.8	1.1
25-34	3.3	1.8
35-44	13.4	6.0
Order of Pregnancy		
First	3.4	2.0
Second to Fourth	4.0	2.8
Fifth to Seventh	9.0	2.3

Fig. 6
THERAPEUTIC ABORTIONS IN NEW YORK CITY
DISTRIBUTION

	1951-53		1960-62	
	Per Cent Dist.	Ratio 1000 Births	Per Cent Dist.	Ratio 1000 Births
All Groups	100	3.5	100	1.8
White	91.8	4.1	92.7	2.6
Nonwhite	5.8	1.4	6.4	0.5
Puerto Rican	2.4	1.1	0.9	0.1

By FRANKLIN A. MUNSEY, M.D., (LIBERAL) PEDIATRICS

The purpose of this meeting is to discuss whether there is a need to update the abortion laws here in Illinois and indirectly, therefore, in the entire United States. It is medicine's duty to stimulate such discussion whenever there might be a need for new laws or modification of existing laws, especially when related to public health. In the State of Illinois, it is lawful to perform an abortion only "for the preservation of the woman's life," as it is in most of the states of the Union. But therapeutic abortions are being done in this state and other states within the Union for reasons other than those expressed in the existing laws. Physicians are constantly confronted with the abortion consideration and will take refuge in official hospital committees for deciding whether the abortion is indicated. Performing a therapeutic abortion with the approval of such a committee, the physician will be less liable for legal prosecution. This, of course, does not make sense; for, while present day science may dictate such

an action as abortion, present day law forbids it. This is certainly a hypocritical attitude and a weak example of our democratic principles of freedom and liberty. Certainly such a predicament can be prevented only by a better law.

How a person feels about modifying the present abortion laws depends to a large degree, I imagine, on one's background and possibly one's religious convictions. Nevertheless, there are some facts about which one should be reminded:

1. It is estimated that one out of five pregnancies in the United States end in illegal abortion or approximately one million per year with the possibility of 5,000 deaths resulting therefrom.^{1,2}

2. Abortion is more a problem of married women with several children, contrary to the popular notion that it mostly involves illegitimate pregnancies.^{1,4}

3. Those of us who desire a modification of the abortion laws are seeking legislation which will remain purely permissive so that

parents could obtain a legal therapeutic abortion under certain conditions if desired, such as suggested by the model penal code, drawn up by the American Law Institute in 1959, which included recommendations for abortions. It stated "a licensed physician is justified in terminating a pregnancy if he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defects or the pregnancy resulted from rape or from incest".

Reliability of Contraceptives

I have been asked to consider reasons for modifying the state abortion law from the point of view of the fetus or embryo. What is the motive that leads to a need for abortion from the fetal standpoint? The motive, of course, is to control an undesired birth at a particular period in the woman's life. Birth control is now generally accepted, and is it not unreasonable of society to insist that a married woman give birth to a child she does not want? Married women use contraceptives now to control the size and health of their families. These contraceptives are not completely effective whether one uses "the pill" or other devices. Failures are indeed well known.

Since birth control measures are not always successful, therapeutic abortion is the logical procedure to have available to prevent a failure which, on occasion, could be a disaster. Such a disaster could occur if a mother should learn during her early pregnancy of the possibility or probability that her child may be abnormal. Under these circumstances, she should be permitted, with the advice of her physician, to have a legal therapeutic abortion.

Abnormalities Including Mongolism

What are these abnormalities that might appear in the fetus to make a mother desire an abortion? Certain abnormalities appear in children because they are inherited from the parents and some may occur because of external influences on the developing fetus. And so, this subject might be discussed under heredity and environment.

When pregnancy begins, the sperm and egg cell have united to form the zygote and there are now present an equal number of chromosomes and genes, or shall we say

characteristics from the mother and father, that decide all the future patterns of growth, except as they may be modified by their environment. It is also necessary that these parental characteristics or genes be in balance. If the genes of one of these chromosomes are present in an extra set, a child with Mongolism will result. Mongolism is a relatively common but unfortunate problem. The size of the problem becomes clear when one realizes that of about 4,000,000 births per year in the United States alone, some 8,000 will be Mongols. It has been known for many years, that the risk of producing a child with Mongolism, climbs steeply in older mothers. It has been shown, that if all women avoid pregnancies after the age of 40, the incidence of Mongolism could be reduced by 30 percent which is one reason why a physician advises his patients to have her children before the end of her reproductive period. Why this is true, we don't know. Suppose we take the case of an elderly pregnant woman who has already had several normal children, the last of whom was a Mongol.

Let us assume that this pregnancy results in another Mongol. Because of the resultant emotional distress, the parents may finally decide, and are able, to admit such a child to a state institution, such as Dixon State School. It is estimated that if this child lives to be 40 years old, which is now not unusual, the cost to the State of Illinois for the lifetime care of this child would be approximately \$80,000.

Where a family already has a number of children, to terminate an unwanted pregnancy in which the risk of abnormality is substantially great, a therapeutic abortion seems justifiable.

Risk of Phenylketonuria

Or take the situation of parents who already have a child with phenylketonuria, the disease for which we have a state law requiring the "PKU test" soon after birth. This disease is a significant cause of mental retardation. This disease has a frequency somewhere between one case in 10-20 thousand births which is greater than, for instance, smallpox in this country. The risk that any second child, in a family in which there is already a child with this disease would be similarly affected, would be one in four, or 25 percent. While the medical

treatment for such a child is now in some instances quite satisfactory, the arrival of a second affected child could be tragic. Only parents who clearly understood the situation and would be willing to accept the risk, should be asked to go ahead with such a pregnancy.

Cystic fibrosis of the pancreas is an inherited disease due to a dysfunction of mucous glands. Not only are the chances of repetition of the disease in a family 25 percent for each child, but the cost is high when the gamble is lost. There is still a reasonable chance that such a child will die after many hospitalizations and treatments. The financial cost can easily exceed \$200 per month which, for more than one child at a time, would indeed put a burdensome strain on most family budgets. To be sure most families can get community help in such a situation, but it is not unrealistic to say that this is unfair to force a pregnant woman to go through her pregnancy knowing that she might have another child with fibrocystic disease. Knowing the risk involved, if such a mother desired a therapeutic abortion, society should have compassion and provide means for her emotional and financial relief.

There are many other inherited conditions which could produce a similar situation. Under these circumstances, an unwilling mother should not be forced to deliver an unwanted child.

Thalidomide Tragedy

One remembers with sympathy the well-publicized story of a few years ago of the unfortunate American woman, involved with the tranquilizer, thalidomide, who had to leave the country to procure an abortion. Some 4,500 children in West Germany alone were deformed by this drug. Fortunately, this experience gave rise to a drastic Food and Drug Law in this country, and very few pregnant women in this country were exposed to this drug.

Some drugs, as thalidomide, are clearly implicated as agents disturbing the growing up process within the uterus. It is suggestive with other drugs, though yet unproved.³ Nevertheless, newer medicines and drugs are continually being developed and used for the benefit of mankind, and we must continue to be alert for another thalidomide.

A young mother with rubella (3-day

measles) in the first two months of her pregnancy may prove to have an abnormal child. Data accumulated over the last few years has shown that 20 percent of such infants will be damaged. Infection with this agent can produce damage to the eye, cardiovascular system, brain, and to the hearing organs of the developing fetus. If the mother's pregnancy were terminated, it is likely that she would go on to be pregnant again and have a normal child. On the other hand, if she delivered her baby and it was damaged, her chances of having another child would be less. A child damaged under these circumstances not only requires considerable care and devotion, but also could be a financial burden and the parents of such a child are less likely to want to have more children. And so, it is reasonable that young normal parents should be given the opportunity to have a healthy normal family by being able to end a seriously endangered pregnancy. To be certain, a vaccine to prevent three-day measles will soon be available. Yes, prevention is better than abortion. But just as we have immunizations to protect our children against diphtheria and tetanus and whooping cough, we still have medicines and treatments for those who contract these diseases. And so, if the usual preventive measures break down, we must have legal means of ending an undesired pregnancy when the probability exists that the child will be deformed. We will have other viruses that affect unborn babies, and probably appropriate preventive vaccines, but we will also have pregnant women who will not obtain the preventive vaccines, and they should have an opportunity to procure a legal therapeutic abortion if desired.

It will be pointed out that since we are dealing only with probabilities in the above mentioned reasons for therapeutic abortion, a certain number of potentially normal children will not be born.

A zygote is the result of conception, and it has been shown that 38 percent of zygotes are spontaneously aborted. What effect does this have on mankind? There is very little effect and certainly no loss especially since many of these zygotes are abnormal. Without getting into the religious and moral question of when life begins, one must remember that a therapeutic abortion is done in the early weeks of pregnancy, by which time the individual fetus has had very little

human effort invested in it. And so, whether the abortion is spontaneous or done intentionally, the loss to the world is zero. Dr. Garrett Hardin, in his discussion on this subject,⁵ points out that persons opposed to changes in the abortion laws will remark, "What if Beethoven's mother had had an abortion?" This is certainly a fair question. But he goes on to state that it is just as relevant to say, "What if Hitler's mother had had an abortion?" And so, the potential of any pregnancy obviously is realized only in the actual birth of the child.

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By EUGENE F. DIAMOND, M.D.

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My position here today is to speak for the fetus and to be his advocate. This is an appropriate assignment for a pediatrician and in keeping with the current modern trend in the relationship between obstetrician and the pediatrician; the obstetrician now recognizes that he is responsible for two patients, the mother and her unborn child.

To consider the fetus not to be a separate person but merely a part of the mother has not been tenable since the sixteenth century when Arantius showed that the maternal and fetal circulations were separate—neither continuous nor contiguous. The genetic material of this separate human embryo is certainly unique, determinative and complete. It is certainly alive since it possesses that hallmark of life—the ability to reproduce dying cells. It can be distinguished from any other non-human species. Once implanted, it requires only time and nutrition. Only two possible futures are open to it. It can become a live human being or a dead human fetus.

Abortion for Fetal Indication

The incidence of abortions done in hospitals to preserve the mother's life, to preserve the mother's health, and for psychiatric indications have all decreased in the past 20 years. The only type of abortion which has increased during that time is the abortion done for the so-called "fetal indication." The use of this term is in itself a misnomer since one cannot justify an abor-

tion on the basis of a fetal indication since no fetus has ever survived an abortion. The justification for such an abortion must then be either a form of euthanasia to spare the child a life with handicaps or for the purpose of saving the parents the happenstance of having an abnormal child.

There is no evidence to indicate that the infant with congenital anomalies would rather not be born since he cannot be consulted and no one really represents him when the abortion decision is made. There is evidence that handicapped persons do value life after they are born since the incidence of suicide among handicapped persons is apparently lower than that of the general population.¹

Risk of Congenital Anomalies

Fetal indications are more accurately parental indications, then, and are based on a reluctance on the part of parents to accept a certain mathematical risk that an infant will be abnormal. Every pregnancy, of course, carries with it the risk of the birth of an infant with congenital anomalies. The risk is never zero percent. It must be stated that the risk involved in *no* presently recognized maternal hazard would support a program of routine abortion. There is no accurate and safe method of recognizing the abnormal embryo in utero during the period when an abortion could be done. Trying to do a karyotype during the first trimester carries an excessive risk of terminating the pregnancy or producing

fetal damage.⁴ Recognizing chromosomal sex is not conclusive since the rare sex-linked disorders now recognized are principally sex-linked recessives. What, then are the risks involved and do they justify the consideration of termination of the life of the fetus. In the situation of maternal rubella during the first trimester, modern prospective, virologically controlled studies indicate that no more than 10-20 percent of infants will be at risk.² Even a figure of 20 percent would have to include such anomalies as remediable cardiac defects, tonal hearing loss and intrauterine growth retardation. When one talks of severe life-blighting congenital anomalies due to German measles, he is talking about cataracts and mental retardation. The risk of an infant suffering one of these calamities is much less than 20 percent. In fact, an 11-year prospective followup of offspring born to mothers contracting German measles during the first 16 weeks of pregnancy showed their intelligence distribution to be normal.³ The risk of an infant being born with any type of congenital anomaly is much less in any non-epidemic year than it is during a rubella epidemic.⁵ Since Mayer and Parkman⁶ of the National Institute of Health have already reported on field trials of an apparently potent rubella vaccine, it is likely that a vaccine will be available before the next rubella epidemic occurs, since epidemics usually occur every five to seven years. The answer to the rubella dilemma lies in this vaccine and not in therapeutic abortion.

Thalidomide-Damaged Children

The problem of teratogenic drug ingestion would also seem irrelevant in this context. Thalidomide was not on the American Market. It is unlikely that a drug with such a teratogenic capability could pass the progeny study requirements now made mandatory by the Food and Drug Administration. Indeed, thalidomide progeny studies on the rat and more recently on the baboon⁷ have produced limb bud anomalies in animal fetuses almost identical to the phocomelia seen in human beings. The thalidomide tragedy was, in a sense, iatrogenic and, therefore, deserving of our profession's utmost concern and compassion. In keeping with noblest medical traditions is the work of Dr. Gustav Hauberg of the Anna Stift rehabilitation school in Hanover,

Germany. In this institution, a team of orthopedists, social workers, and teachers have been engaged in the developing of abilities of thalidomide-damaged children so that, despite their heavy handicaps, they will still value life. Mental and psychological development has been normal, in most cases, and higher education potential is attributed to most. Thus even such a poignant situation as the birth of 7,000 phocomelics can have its positive aspect when medical resources are properly mobilized. The best preventative against the recurrence of such a tragedy is the basic reluctance of obstetricians to give any new drugs to pregnant women.

Cult of Perfection

It is difficult to formulate a therapeutic principle which would apply to the various situations posed by exposure to drugs or disease. If the principle is that it is better for eight or nine normal babies to die than for one or two abnormal babies to be born, then I must say that I reject this principal as wasteful and unreasonable. It seems to me that this viewpoint derives from a cult of perfection which says that life is not worth living unless it is free of handicaps. That *vita* is not *vita* unless it is *La Dolce Vita*.⁸ Experience in working with handicapped children would suggest that human nature frequently rises above its impediments and that, in Shakespeare's words, "Best men are molded out of faults and, for the most become much more the better for being a little bad."

Certainly the entire medical profession, not just abortion-law revisionists, has compassion for victims of forcible rape and incest. There is a question however, as to the true dimensions of this problem. Studies on human fertility would suggest that not too many pregnancies are likely to result from a single act of forcible rape. I am informed, by the local states attorney's office that their staff could not recall a single incident of such a pregnancy in an experience covering about nine years of prosecution for rape. If such a pregnancy were to occur, there is no scientific evidence that psychological trauma would be prevented, unaffected, or intensified by compounding the shame of rape with the possible guilt of abortion. In the case of statutory rape, there is likewise a question as to the relevance of therapeutic abortion. Teenage

girls who become pregnant are largely a group characterized by social isolation and alienation from their parents. Frequently, they look forward to the birth of the infant as a further loneliness compensation and, therefore, do not present themselves for therapeutic abortion consideration. Incestuous pregnancy is no less a difficult problem. Many such pregnancies are not recognized or admitted until physically obvious and beyond the time when abortion would be possible. Many cases of alleged incest will fail of recognition because the victim or her mother will shrink from the financial ruin involved in accusing the father or the social ruin involved in convicting a brother. In 1966, there were only 12 indictments for incest entered in Cook County and only a fraction of these involved pregnancies to which therapeutic abortion would have related under any law.

Unwanted Child or Unwanted Pregnancy

Much is made of the appeal to prevent the birth of unwanted children. It seems to me that there is a confusion involved here which results from the failure to distinguish between the unwanted child and the unwanted pregnancy. In 15 years of experience with the parent-child relationship, I have very rarely encountered a mother who asked to be rid of her child once she had taken it home from the nursery. I have encountered many mothers, pregnant with their third or fourth child who undergo a kind of panic which requires the sympathetic support of their family doctor and their husband. According to Hoerck, 75 percent of women who were refused abortion under the Swedish system, went on to have their babies and were happy with them. According to Aren and Amark, more of these women have an improvement in their mental adjustment than a deterioration of mental health. I wonder if we really want a situation like that in Denmark for example where the principal indications for abortion are (1) the stress syndrome of housewives (2) symptoms of insufficiency and (3) impending exhaustion.¹¹

God-Like Qualities

One of the uninsurable risks of medical practice is that we sometimes begin to believe in the phantasies of our patients. Patients may ascribe god-like qualities to

us, but I doubt that they will approve of our acting them out. The notion that a physician should be allowed to perform any abortion he chooses within the framework of the physician-patient relationship is a unique and unprecedented request for any profession. Does the lawyer ask that since law is his specialty, laws should be left to his conscience? Does the educator suggest that his position as an educator entitles him to decide when prayer should occur in public schools? A doctor may know how to do an abortion; he does not necessarily know when it should be done or if it should be done at all.

Ninety percent of abortions in the United States are performed on women who are married, healthy, and living with their husbands. Ninety-five percent of the fetuses destroyed in these abortions would have been born normal. If we accept the Kinsey statistics, 88-95 percent of abortions are performed by technically competent doctors of medicine. What do we expect to gain, then, from changing the law?

It seems to me that we have a good law in Illinois. When physicians throughout the state were asked, through the *Illinois Medical Journal*, to report cases where the present law had worked to the detriment of the physical or mental health of the mother by depriving her of a needed abortion, no such cases were reported. During the past five years, in this state, we have had five maternal deaths due to septic criminal abortion, an average of one a year. This must be close to an irreducible minimum. If the law is changed to allow for a vast increase in the number of abortions performed, there will be many more lives lost and these will be the lives of unborn children. The mortality is 100 percent for them. Most states recognize that the unborn child does have rights under the law. A mother may sue for the support of her unborn child or may hold a defendant liable for injuries sustained by her unborn child as a result of accident or assault. An unborn child may share in an inheritance or workmen's compensation benefits. A pregnant woman convicted of a capital crime may not be executed until after her baby is born. The constitution in the Fifth Amendment provides that no person shall be deprived of life without due process of law. It is certainly a matter of pause for the medical profession to decide whether two doctors in agree-

ment or even an "Abortion Committee" constitutes due process.

Millions Spent for Unborn

It seems ironical that when we have established a National Institute of Child Health which specifically directs its attention to child development from the time of conception and while tens of millions are being spent by various national foundations to improve the lot of the unborn, that we should see in this day a movement for more liberal "fetal indications" for abortion.

If you ask me therefore to speak for the fetus, then speak for him I will. I speak for him intact or deformed. I speak for him wanted or unwanted. Yes, and I speak for him be he illegitimate or high-born. I am for life and the preservation of life. I believe that any life is of infinite value and that this value is not significantly diminished by physical or mental defect or the circumstances of that life's beginning. I believe that this regard for the quantity and not the quality of life is a cornerstone of Western culture. I believe our patients are served best by a medical ethic which also holds this principle sacred.

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The Illinois abortion law is brutal in its simplicity. I need not repeat it for by now you have heard it. However, it's simplicity is deceptive for it fails to define the term "life." Webster's Unabridged Dictionary defines life as "The quality or character which distinguishes an animal or plant from inorganic or from dead organic bodies and which is especially manifested by metabolism, growth reproduction and internal powers of adaptation to environment." In the sense of the above definition, the law, to my mind, is not only brutal but even hypocritical. For on the one hand we are ready for a few dollars to issue a license to anyone to terminate life as defined above, for the sake of sport (I mean, of course, fishing and hunting) and on the other to become sanctimonious about it.

If, however, life were to be coupled with the concept of "woman's life" as it is, then

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what does that mean? It implies to my mind the differentiation of human life from animal life and that which constitutes the term human. We are a species of animal, all right. If a specimen is cut open, the same kind of guts are found as in a monkey, dog or rat. We have to eat, drink and breathe, and much as we deplore the fact, like any other animal we produce waste products which must be disposed of. Our method of reproduction, despite some bizarre aspects, is not unique. However, the development of symbolic language, of conceptual thought, of culture, has drastically altered our behavior.

When Life Is Unbearable

Yes, as a biological entity man is definable and the fulfillment of his biological needs are definable, concrete and definite. However, those characteristics which make

him human, his common sympathies, passions, feelings and failures are much more abstract, more varied, less concrete and more difficult of definition. When one of our historical heroes makes the public declaration of "Give me liberty or give me death!" he pronounces a nationally valued attitude, i.e. that there are conditions under which life is unbearable. We send men into battle to die for "our way of life" not just life. As a citizen and human being I admire Patrick Henry; as a psychiatrist I can attest to his formulation that there are conditions under which life is unbearable, and one of those is, of course, a pregnancy which threatens the mental health of the woman, the potential offspring and even that of her family.

Abortion is a highly charged emotional, moral, ethical, legal, social, economic and medical problem which is so complex and interrelated that it is almost impossible for the physician to isolate and consider solely medical factors to the exclusion of the other elements. However, while I could very well do without it, I nevertheless cannot fulfill my obligation to my profession and society by avoiding the complex and painful decisions as to what is best for my patient, her family and community by the expedient maneuver of hiding behind a law which would otherwise brand me a criminal.

Abortion Seekers Vary

The conditions under which women come to see us regarding abortion are certainly varied. She may be the mother of a large family at the end of her tolerance, or young and unmarried; she may have been a victim of rape, incest, or seduction under drugs; she may have had a series of sexual affairs with little self control, or a young wife taking every precaution to postpone pregnancy. She may have had rubella, or ingested a drug which makes her believe that her youngster will be a monster; she may glory in free love or have religious views against abortion; she may be mentally ill, depressed, angry with herself, the father, or anyone who refuses to do what she wants. Anxious, pathetic, courageous or defiant and she may even consciously exaggerate her symptoms.

These situations arouse different reactions in those about her—even in the psychiatrist. One may feel sympathetic with some, i.e. the victim of rape or incest; irritated by the casual amateur, counter-aggressive to the

defiant and angry. As psychiatrists we are trained to understand not only the patient's reaction but also our own. However, we may not always succeed. Thus it may be worthwhile to remember Becket's temptation in T. S. Eliot's "Death in the Cathedral"—to refrain from doing the right thing, simply because there is a wrong reason for doing it—and because it might seem to others that this was why it was done.

How Likely Is Suicide?

In practice there are two main questions. Will the patient's health break down at times irretrievably, or will she commit suicide if pregnancy is allowed to go on? It is indeed a harrowing decision for the psychiatrist to make. How does he judge? Clearly not from the woman's statement alone, or all she would have to do is to threaten suicide and she would be aborted. It is not easy to judge how likely any depressed person is to kill herself, more difficult if one has never seen the patient before, and still more difficult if no records of her previous history are available. Clearly our assessment of and knowledge of the patient must be complete. We must assess the patient's ability to withstand stress and must also assess the nature and magnitude of the stress to be met.

With respect to the key question as to whether there are psychiatric conditions which are life threatening to a mother with an unwanted pregnancy, one may state that only the depressive state with imminent suicide could be considered to be life threatening. But as already formulated by me earlier, life threatening has other than the mere biological significance and I would, therefore, like to put forth other indications for abortion on psychiatric grounds.

Clinical Decision Without Conflict

Cases in which there are clear cut grounds for believing that continuation of pregnancy will result in recurrence of a schizophrenic reaction, or in which there is a previous history of puerperal depression with suicidal implications should involve the psychiatrist in a clinical decision without conflict, conscience or emotion. These cases are in fact similar to other terminations recommended on medical grounds.

It is in the more subtle situations with less defined and self evident indications for

abortion where no expertise may be needed, that our hearts must grow strong, and our readiness to use our painfully acquired skills could be rewarded for the benefit of all. As an example it is generally accepted that poverty, marital strife, poor housing, financial difficulties, adverse work situations and emotional conflicts can produce mental and physical disorders. And yet if an unwanted pregnancy occurs these conditions are labelled as "social" by some psychiatrists who refuse to consider the patient as a whole, and who excuse themselves by narrowly defining "psychiatric indications" for terminating a pregnancy. In considering the possible deleterious effects of pregnancy, and the desirability of terminating it, psychiatrists have to bear in mind not only the direct but also the remote effects on the health and well being of the mother.

Evaluation of Mental Health

Discussion which involves the "social" environment usually taken with the help of social workers are part of the every day practice of psychiatry. Psychiatrists bring to such discussion expert knowledge and a responsible professional attitude and it is natural for general practitioners and obstetrician-gynecologists to call upon them for help in evaluating these factors for the future mental health of the patient. On the other hand I believe that we should resist the notion to terminate a pregnancy lawfully merely on the grounds that it is inconvenient to either or both parents.

Another serious indication for abortion should be the possibility of a substantial risk that, if the child were born, it would be seriously handicapped. An example is the exposure of a pregnant woman in her first trimester to rubella or thalidomide. Admittedly here I am dealing only with probabilities; abortion on these grounds would mean that some potentially normal children would not be born. However, provided the effects of legislation in this connection remain purely permissive and no social pressure is brought to bear on parents to seek relief from the possibility of bringing an abnormal child into the world, the inclusion of this ground for termination is likely to be beneficial to many a parent and to society.

Recognized States of Emotional Strain

When a seriously emotionally ill woman,

or one who is suffering from severe chronic mental illness, becomes pregnant, there is a *prima facie* case for therapeutic abortion. When the condition is in some lesser degree of illness, or character disorder, this should not be regarded as automatically providing grounds for termination of pregnancy. One has to evaluate the total life situation past, and projected, to make life bearable for the woman and the child who must come into the world expecting to be wanted, loved, and cared for. I do not at the same time regard termination as the easy way out to be taken when in doubt.

In the pregnant woman there are well recognized states of emotional strain. The possibility of a break with health must be viewed in the total context of the woman's individual, family, social and life experiences. This calls for a careful evaluation and, frequently, for the opinion of an experienced psychiatrist. This provision should also apply to such situations as rape, provided, of course, that the physician was satisfied that rape has occurred.

I would make the provision that therapeutic termination of pregnancy should always be voluntary and at the request of the pregnant woman herself and with the agreement of her husband, should she be married, except when, as a result of severe mental illness, the woman is incapable of forming a rational judgment, in which case the nearest relative or guardian should give his or her consent.

Cost of Psychiatric Evaluation

What I am trying to say is that certain courses of action in relation to therapeutic abortion should be permissible by law because they contribute according to the best available knowledge, to the promotion of health and the prevention of disease. In this belief I would not presume to dictate to those physicians who cannot personally adopt this pragmatic view of medical ethics. They must clearly be free to adhere to ethical standards prescribed by their religion or philosophy.

If after considering all these factors a psychiatrist whose skills and uncommon sense about these matters should form the opinion that the mental health of the mother and the whole family would be promoted by termination, then it should be lawful for him to recommend it. The cost for psychiatric evaluation should not be

prohibitive and should be available at clinics to avoid discrimination of those who cannot afford private care. Ultimately the safeguards against irresponsibility must lie in the integrity and competence of our profession. Once psychiatry has been canonized as a medical discipline, we as psychiatrists must be given the legal safeguards to practice it responsibly. I reject the notion

that those who are untrained in my discipline can make better judgments on those factors which influence mental illness or mental health than we can. All that I ask for myself and my colleagues, is to be given the freedom to practice my art and science as licensed by my state to be responsible, and as certified by the Board of Psychiatry and Neurology to be competent.

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In evaluating what contribution I might make to this public forum, I was increasingly impressed that behind the argument over abortion broader issues were involved.

These broader issues are science, religion and human behavior, the implications of which require careful scrutiny.

An understanding of the conflict here today requires recognition of the rapid change in social, religious and individual ideals. Understanding also necessitates awareness of advances in knowledge about human development and human psychology.

The issue over abortion seems related to the relationship between these changing ideals and advances in scientific knowledge. The questions about abortion seem to symbolize the growing conflict over religious systems' dominance in legal, social and cultural systems.

The discussion that follows is an effort to achieve an overview of abortion, its meaning and potential consequences, without any attempt to define or defend an abortion morality.

Scientific Evidence Ignored

Extreme positions, for and against liberalization of present abortion laws seem to derive from a fundamental innocence of science or religion.

For example, the view that equates a newly fertilized egg with a human body is suspiciously preformationist and ignores fundamental scientific evidence.

What requires further differentiation here is the question of whether an individual human is aware of his unconscious view of earliest pregnancy.

The vast morphological difference between earliest embryos and an advanced,

human-like, fetus seems to be, at least, superficially understood. However, such intellectual understanding does not preclude an unconscious conviction that even the earliest cell union "means" human life. This unconscious, inner, conviction can exist, even in the absence of religious dogma. An aborted pregnancy in such a person might subsequently yield an inner fantasy that a human life had been destroyed.

Those against any change in the law, often for religious reasons, would allow an incestuously produced pregnancy to proceed to term, which tends to treat mankind's only universal taboo with less abhorrence than one might expect.

Taboos Based on Religious Ethics

Support of such an incestuous pregnancy seems to symbolize, paradoxically, the most primitive, anti-religious, anti-civilization forces in mankind.

In the other extreme, it is unwarranted to assume that simply explaining scientific data will undo deeply rooted abortion taboos based on religious ethics.

In addition, the view that any physician should be licensed to abort, presumes a minimum integrity and sophistication about total human experience that is unsupported in fact.

What is meant here by "experience" needs definition. It is not necessarily equal to alleged religious truths nor commensurate with scientific paradigms. It is that which is felt and has meaning and impact internally for the individual.

I am, personally, in support of an increasing importance for scientific knowledge in shaping human experience and in framing ethical systems. Thus, I favor changes in the abortion law in early pregnancy and

even more, strongly advocate measures preventing pregnancy where needed.

However, what I am suggesting also urges consideration of the actual *intrapsychic* impact of the taboos of religion and civilization. These statutes, written and unwritten, exist *in fact*, regardless of whether they seem supported by scientific evidence. Their long standing in the body of human ethics plays a crucial role in individual human experience.

For example, if in fact the people involved (mother, father, physician) in an abortion have an internalized unconscious attitude that links abortion with murderous or sexual sin, then the guilt reaction to the abortion will be little modified by reason or science. The resulting anxiety, feelings of wrong doing and expectations of punishment derive from unconscious attitudes about God, creation, development, right and wrong, and of course abortion.

These reactions and attitudes are the result of a complex mixing of biological and psychological drives, the demands of civilization, and experience; much of which is unconscious. They will only gradually yield to increases in awareness and changes in civilization's statutes.

Potentially, A Sense of Evil

Thus for a woman an abortion could, potentially, be the forerunner of a tormenting sense of evil and a serious encroachment on womanliness and motherhood. For a physician or father it could potentiate self-denunciation, feelings of loss of integrity and masculinity.

On the other hand, in people where scientific evidence has been more thorough-

ly integrated the response to abortion may not be psychologically damaging.

In attempting this overview of the issues involved—scientific, religious and psychological—what evolves is a complexity of possibilities that defies uniform prediction.

It seems to me that the advisability of an abortion can be determined, but with difficulty.

On the spot prediction of individual human response to abortion by single unenlightened physicians seems ill-advised because of the potential psychological pathology. However, early abortion seems reasonable, in carefully evaluated cases where there has been consideration of the religious, scientific and emotional forces involved.

Encroachment on Individual Rights

The present laws, based as they are on a morality not universally accepted and devoid of science seems a meager basis for statute and an encroachment on individual rights.

In the face of changing human ideals of religion and morality, it seems particularly important that child birth should be selected as so conflictual a staging area.

On the surface it is explained by our civilization's abhorrence of killing. Although as a society we verbally condemn aggression; that is, we, our religions, and our governments are against murder; only minimal scratching of the surface exposes this as verbosity unsupported by our deeds. These deeds include the aggression in fact, fostered historically by individuals, religious systems and governments, aggression that

**Do you think abortions should be allowed when
THE MOTHER'S LIFE IS IN DANGER?**

MALE & FEMALE	
Yes	876
No	122
Depends	8
No Answer	7
1	TOTAL 1013

has fought wars, campaigned for genocide and ruthlessly abetted the subjugation of minorities.

Man's introspectiveness and search for worldliness presses for a more open awareness of motives and issues. Society should insist on a scientifically and psychologically sound differentiation between murder and the extraction of a small mass of cells, early in pregnancy.

There is a large national commotion over abortion. In view of our national glorification of power and aggression such horror of abortion must have other or additional fore-runners.

I am suggesting that the pressure for liberalizing abortion laws does not run contrary to our national posture on murder and aggression as much as it challenges the legal and religious establishment per se. This resistance to change in the law seems

to touch on sexual taboos, especially in women. It may reflect our double standard of sexuality and a legislative device to maintain our unconscious attitudes about women and mothers.

Interestingly, the tumult for greater freedom about abortion parallels the contemporary surging for greater sexual expression. The egress of these pressures seems related to a changing conscience and a diminished conviction about religious assurances.

Advocacy of this conservatively administered change in the law seems a logical evolution in the codification of society.

This codification should reflect the reasoning, methods and proofs of science that apply to human development and human experience. Law deriving structure in this way from science need in no way obviate humaneness or intrude into the piety of the individual.

**Do you think abortions should be allowed when
THE PREGNANCY RESULTED FROM RAPE?**

MALE & FEMALE	
Yes	784
No	217
Depends	3
No Answer	9
2	TOTAL 1013

**Do you think abortions should be allowed when
THE MOTHER'S MENTAL HEALTH IS THREATENED?**

MALE & FEMALE	
Yes	741
No	253
Depends	9
No Answer	10
3	TOTAL 1013

There is only one justification for taking a position on the public health aspects of abortion laws. It is simply this: the medical and scientific community does not control the times at which society asks questions of it. If it chooses not to reply, claiming inadequacy of information, it abdicates its voice to others less qualified. I cannot defend any position on the basis of adequate data, because all the available data about the magnitude of the problem in the U.S. are pitifully inadequate. Neither can I keep silent for the sole reason stated earlier.

How important is illegal abortion as a public health problem in the U.S. and in Illinois? Taking the largest estimates, illegal abortion does not approach heart disease, cancer, mental illness, diabetes and high blood pressure as causes of death, illness and personal tragedy. The death toll as a result of cigarette smoking and drunken driving dwarfs by comparison the largest estimate of the death toll from illegal abortion. And yet, such abortions are not negligible public health problems. Taking the lowest estimates, there are far more illegal abortions each year in the U.S. than there are narcotics addicts of both sexes. The lowest estimate of the number of women each year with illegal abortion greatly exceeds the number of women who develop new cases of T.B. each year in the U.S. It is probable that more women of child bearing age die of illegal abortions than of all forms of leukemia put together.

We are therefore dealing with a public health problem of moderate proportion. Not of the proportion of the great killers of our time—heart disease, cancer, stroke and accidents—but nevertheless a problem more important than other public health issues which receive serious attention.

Is it likely that the health problems associated with illegal abortion will disappear? One does not like to propose legislative remedies for problems that are going to solve themselves. Regrettably, it is extremely unlikely that the problem will disappear. Rape and incest will always be with us. Among those for whom another pregnancy is a highly threatening event and who can use contraceptive devices in good conscience, there will always remain ignorance, faulty techniques, forgetfulness, or the haste of passion. Unwanted pregnancies—and I use the term unwanted only in the sense that large numbers of women take major risks to get rid of them—will continue to occur. Can we ever again experience something like the thalidomide tragedy? Yes, we can. In spite of more stringent federal regulation on new drugs, absolute safety cannot be guaranteed and cannot even be approached. Some kinds of drug toxicity become evident only after widespread use over long periods of time. Moreover, it is possible that we shall learn that other viruses besides rubella harm the fetus. The likelihood that unwanted or

**Do you think abortions should be allowed when
THE UNBORN BABY IS EXPECTED TO BE DEFORMED?**

MALE & FEMALE	
Yes	725
No	281
Depends	7
No Answer	0
4	TOTAL 1013

potentially damaged children will be born will remain with us.

If then we have a moderate public health problem in the U.S. and in Illinois which will remain with us during the foreseeable future, what can we do to deal with the problem? If a law were passed which changed a large proportion of abortions from the illegal to the therapeutic category there would probably be two beneficial effects. Much more precise knowledge of the magnitude of the problem would develop and future measures both medical and legal could be based on hard data rather than

estimates. It is probable that morbidity and mortality will go down in proportion to the number of abortions done by physicians using operating room techniques. These are remarkably safe procedures in competent hands. It is not my purpose to consider here the effect of the present laws and their intrusion on the doctor-patient relationship, nor their efforts on morale, behavior, religious institutions and practices.

In summary, we have a public health problem of moderate dimension likely to remain with us and in large part a problem remediable by legislation.

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Back in 1860, Dr. Oliver Wendell Holmes delivered an address before the Massachusetts Medical Society entitled "Currents And Counter-Currents In Medical Science." This address was an endeavor to set up a counter-current to reverse the excessive therapeutic activity characteristic of the physician. Dr. Holmes attributed this excess, in great part, to the immense outside pressure from the public which was forcing the physician to active intervention of some kind; and, in smaller part, to the physician's tendency to self-delusion concerning his accomplishments. In the course of developing his thesis, Dr. Holmes gave us one of those profound, timeless insights that deserves our most sober consideration as we attempt to render a professional judgment concerning the wisdom of extending indications for induced abortions.

He called attention to the unsuspected, close "relation between the medical sciences and the conditions of society and the general thought of our time" with this statement:

That although "theoretically medicine ought to go on its own straightforward inductive path without regard to changes of government or to fluctuations of public opinion . . . the truth is, that medicine, professedly founded on observation, is as sensitive to outside influences, political, religious, philosophical, imaginative, as is the barometer to the changes of atmospheric density."¹

Adhere to Medical Principles

Dr. Holmes decries this susceptibility of medicine to non-medical factors and urges the physician who has any respect for his profession to firmly adhere to the medical principles of his science and art.

A similar thought expressed more recently by two leading social scientists in a book entitled *Human Behavior: An Inventory Of Scientific Findings*² provides a contemporary counterpart which also deserves our sober consideration.

This is Time Magazine's version of the book's conclusion:

**Do you think that
ALL ABORTIONS SHOULD BE PROHIBITED?**

MALE & FEMALE	
Yes	100
No	913
5	TOTAL 1013

Today's behavioral scientist (the epitome of the contemporary scientist) is "a depressing creature with a vast talent for distorting reality because of psychological needs. (He) thinks what fits his wishes, says what pleases his peers, avoids conflict and protects his neuroses. He votes with his friends, wants what he has to work for, and thinks his group or organization ranks higher than it does. If threatened with disillusionment, he simply slides into fantasy, and reality pays the price."³

The following are some illustrations of this tendency of scientists (and the mass communicators who follow them) "to distort reality to fit their wishes."

Number of Deaths

1. The misstatement that: There are 10,000 deaths a year from illegal abortion.⁴

But the fact, as established at a three-day Planned Parenthood Conference of 43 experts and as reported by Dr. Mary Calderone, its medical director at the time, is:

"I can tell you that in 1957 there were only 260 deaths in the whole country attributed to abortion of any kind. Abortion is no longer a dangerous procedure, and this applies not just to therapeutic abortions as done in hospitals, but also to so-called illegal abortions . . ."⁵

That was the figure for 1957. In 1963, for the U. S. as a whole, there were 275 deaths attributed to abortion of any kind. Of these deaths only 114 were due to abortions that were criminal, self-induced, or without legal indications. Total maternal deaths for the U. S. in 1963—and this includes all other maternal deaths as well as abortion deaths—only numbered 1,400.⁶

What makes the statistic of 10,000 deaths yearly somewhat outlandish is that the total number of deaths of women in the reproductive age period is only, mind you, only 50,000 yearly. If the 10,000 figure were correct, it would mean that one out of five women between the ages of 15 and 45 who die dies of an abortion. This hardly leaves room for deaths from other causes. Deaths from cancer, cardiovascular and kidney disease number by themselves about half of the 50,000 deaths of women between the ages of 15 and 45. Deaths from automobile and other accidents number another 7,000. Additionally there are lesser numbers of deaths from influenza and pneumonia, cir-

rhosis of the liver, diabetes, tuberculosis and all of the numerous other causes.⁷ It is a preposterous figure and should not be used, least of all by the medical profession which has a responsibility to speak accurately. The figure, incidentally, is extrapolated from some highly unrepresentative data collected from patients attending a New York City birth control clinic in the pre-antibiotic years of 1925-1929.⁸

Number of Illegal Abortions

2. The misstatement that: There are a million or a million and a half illegal abortions a year.⁹

But this is what a special committee on abortion, chaired by Dr. Christopher Tietze and including Dr. Alan Guttmacher, says: "A plausible estimate of the frequency of induced abortion in the U. S. could be as low as 200,000 and as high as 1,200,000, depending upon the assumptions made . . . and the assessment of bias. *There is no objective basis for the selection of a particular figure between these two estimates as an approximation of the actual frequency.*" (italics added).¹⁰

Since there were only 3,500,000 live births in the U. S. in 1966,¹¹ and since contraception has long been available to 5/6ths of all women at reproductive age, the figure of one million abortions yearly, which gives a ratio of abortions to live births of 1 to 3.5 seems highly improbable. In Sweden where abortion is legalized and where abortion has become a cultural pattern, the rate of abortion to live births in 1963 was only 1 to 31 or nine-fold less.¹²

When Does Human Life Begin?

The same distortion of reality occurs when we move from statistics to the science of embryology. Abortion protagonists refer to the unborn offspring as a part of the mother not significantly different from sperm or egg,¹³ a piece of tissue, an inchoate being, a small mass of cells, a blob, a parasite, a tumor.

When Life Magazine editorializes in favor of abortion, it states, "A fetus is a living body—but not a human being until birth."¹⁴ However in their earlier unique pictorial story, "The Drama of Life Before Birth," Life states, "The birth of a human life *really* occurs at the moment the mother's egg cell is fertilized by one of the father's sperm cells." ¹⁵ (italics added).

We find a similar situation with the New York Times. A recent article on "The New Medical Specialty, Fetology—The World of the Unborn" states, "Scientists generally agree (that at) the coming together of egg and sperm . . . conception takes place (and) a new life . . . a new human being . . . begins."¹⁶ It refers to it as a "small miracle." This scientific fact, however, is not reflected in its editorial pages.

Safety of Legal Abortions

Another example of the scientist's capacity to distort reality is Dr. Alan Guttmacher's recent testimony before the New York State Assembly Committees on Code and Health that legal abortions are "magnificently safe."¹⁷ (When we can no longer say this about an aspirin tablet, one wonders what miracle of science permits us to say it about an abortion.) Contrarily, however, Dr. Christopher Tietze, director of research for the National Committee on Maternal Health, and a close working colleague of Dr. Guttmacher, is reported as saying something quite different at Johns Hopkins University. He urged that "an international research effort be undertaken to find safe and simple methods of terminating pregnancy."¹⁸

Finally, I would like to call attention to a particularly grievous error which appeared in the Chicago Daily News in its recent series on abortion.¹⁹ It inferred that Hippocrates was a hypocrite; that at the high level of pious declaration he said one thing, but in the daily expediencies of practice he did another. The News contrasted a case history—in which Hippocrates helped a young lady to abort, to his great oath—in which he clearly and unequivocally speaks against abortion. But there is no such case history written by Hippocrates,²⁰ and the medical profession has a right to resent the slandering of this great pagan physician who gave medicine its moral imprint and eternal dedication to the preservation of life and who first distinguished medicine as a profession from that of a technology or trade. The error originated with Dr. Frederick Taussig in his book on the medical and social aspects of abortion published in 1936,²¹ and has been repeated with great avidity and regularity by proponents of abortion who fail to distinguish fiction from fact.

Experiences of Other Countries

These are just a few examples of how we get carried away today by our desires and enthusiasms. The problem continues as we make claims for future benefits to be derived from a relaxation of the abortion laws. Last fall at the annual meeting of the American Public Health Association in San Francisco, Dr. Christopher Tietze admonished us, before embarking on any changes of abortion laws, to study the experiences of other countries, from which we have much to learn.²²

These are some of the utilitarian and pragmatic things we can learn:

1. That where abortion laws are relaxed, contraception is discarded or ignored. This seems to be a universal phenomenon. Actually abortion now is the most widely used single method of birth control throughout the world, according to Prof. Ronald Freedman.²³ Rather than take a powerful, disruptive, dangerous hormone pill, or carry a permanent foreign body inside, or use a diaphragm or jellies women prefer to accept nature as it is. In Japan women who are active sexually and don't want babies find it simpler to have abortions approximately every eight months until sterility sets in.²⁴

Abortions Steadily Increase

Dr. Franc Novak of Yugoslavia devoted an entire talk to this subject at the Singapore Conference of International Planned Parenthood. Under the title, "*Why Does Contraception Meet So Many Difficulties In Superseding Abortions?*" Dr. Novak said the following:

"In spite of great needs, contraception is very slow in spreading while abortions are on a steady increase, threatening to become a real epidemic. Why do women not prefer contraception, which is simpler and less unpleasant, to abortion? In our country, there are no visible obstacles to modern contraception; on the contrary, it is even supported, encouraged and stimulated. In a socialist society prophylaxis stands in the foreground of medical thinking and acting. It is included in our health service whose duty is to put it into practice Our propaganda meets with no obstacles. Lectures, pamphlets, films, radio and television are at our disposal—and yet our progress is slow. Religion represents no obstacles in our country. . . . It seems that the greatest obstacle

to spread of contraception lies in liberal permission of artificial abortions. Through widespread abortions a state of mind is created with women that abortion represents the chief means for planned parenthood."²⁵

Pregnancy Rate Increased

At the same meeting Dr. Hans Harmsen of West Germany stated that the legalization of abortion increased the pregnancy rate, and Dr. Tietze added that with abortion legislation, contraception was practiced in a more slipshod manner.²⁶

The conclusion is clear. Relaxation of the abortion laws will stimulate the need for more abortions and will increase rather than decrease the abortion problem.

2. Contrary to general belief and propaganda, liberalized indications for abortion along the lines envisaged for the United States in imitation of Sweden will *not* reduce the incidence of criminal abortions as alleged. Dr. Tietze in his San Francisco paper entitled, "Abortion In Europe," states that although "one of the major goals of the liberalization of abortion laws in Scandinavia was to reduce the incidence of illegal abortions," this was not accomplished. Rather, as we know from a variety of sources, both criminal and total abortions increased.²⁷

Even were we to permit abortion on demand as in the Eastern European countries which would result in "spectacular increases in the incidence of legal abortions," as compared to Sweden, even then criminal abortion would still persist.²⁸

More Abortions Than Births

Let me illustrate this with Hungary which has the highest rate of legal abortions and where abortion is available on request. Whereas for each 1,000 live births in Sweden there are only 32 legal abortions, in Hungary for each 1,000 live births there are 1,400 legal abortions, more abortions than births, and 44 times the Swedish number. For the U. S. this would be close to five million legal abortions annually as against three and half million live births. Despite this massive blood bath, which Dr. Hartman tells me is resulting in increased depressive reactions and breakdowns among guilt ridden Hungarian physicians,²⁹ illegal abortion remains. Dr. Tietze thinks illegal abortion survives because of the "relative lack of privacy of the official procedure."³⁰

It seems apparent then that anyone knowing these figures would be less than honest, and to some extent cruel, if he continued to urge a change in abortion laws along the lines of the so-called model code of the American Law Institute, for the purpose of rescuing women from criminal abortions.

Abortions Are Lucrative

3. To be most pragmatic, let us not forget that the liberty to abort makes the physician more like a god than is good for him. Abortions are also lucrative. We've experienced the prevalence of unnecessary operations and the invasiveness of the attitude that justifies them. We know that in the effort to please patients some of the profession have a great talent for descending to the lowest common denominator. If today some licensed physicians practicing in approved hospitals disregard both the letter and the spirit of the legal therapeutic abortion by performing abortions that are in no way "necessary for the preservation of the woman's life,"³¹ what reason is there to think that tomorrow were the law made more permissive and the indications more tenuous, physicians would be more respectful of the law? We will again hear the old refrain by an even larger chorus, "If I don't do it somebody else will." But this time we will be dealing with delicate decisions of life and death.

4. Increased numbers of abortions universally result in increased impairment of both physical and mental health. That is why none of the countries where abortions have been extended are happy about their high and increasing abortion rates.

Abortion As Birth Control

Dr. Novak from Yugoslavia in the article referred to above simply refers to "The evil consequences of liberally permitted abortions..."³² Dr. Klinger of the Hungarian Central Office of Statistics commenting on the Eastern European experience states, "... induced abortion is . . . one of the chief means of birth control. Its deleterious effect on health is sufficient reason to change the present-day situation."³³

"The great Soviet experiment of free abortion, which continued for eight years after the revolution, still affords us the best evidence of physical injury following the operation" according to Dr. Müller.³⁴ Dr. DeLee reports the morbidity of that experience as follows: "Russia, which has legal-

ized abortion, has completely reversed its position under the accumulated bad experience with 140,000 such operations a year. The authorities call the practice a serious psychic, moral and social evil and inherently dangerous even when performed *lege artis*. They found trauma—uterine perforation, cervical laceration and stenosis, parametritis, etc.—ectopic pregnancy and biological trauma—amenorrhea, sterility, endocrinopathies. Subsequent labor was more often pathologic: placenta praevia, atonia uteri, adherent placenta, postpartum hemorrhage and postpartum fever (32%).”³⁵

Abortion in Japan

At the Singapore meeting of International Planned Parenthood, Dr. Nobuo Shinozaki, of the Japanese Ministry of Health and Welfare, made these revealing remarks about abortion and the quality of living in Japan.

“To be honest, in spite of the increasing economic development, our national life is not by comparison so much happier . . . Certainly the technical advance since the war has been remarkable, but it does not follow that parallel improvements have been made in the actual people . . . In short, modern civilization or culture has caused human beings to modify human nature to part of a machine, which is toward an ‘alienation’ of the human being. As a result we find in Japan that death by accident or suicide is highest in the under 24 year age group. To be added to this is the damage to the nervous system and sexual problems, especially sexual apathy and impotence. The practice of family planning is inevitable and it has a very important role in every era but where it combines with other factors to ignore the quality of human life it must be reassessed. In conclusion I recall the saying: ‘The longest way round is often the shortest way home.’ ”³⁶

Serve Equally And Equally Well

I will close with some observations as a public health officer who shares with other physicians the obligation of his profession to serve all human beings not only equally, but equally *well*. I add *well* to *equally*, because it has long been known that private patients are the recipients of more meddling midwifery than ward patients—to use the famous phrase of a famous Chicago obstetrician, Dr. Rudolph Holmes. If affluent

patients have a greater incidence of induced labors or induced abortions, it does not follow that true democracy demands that the poor also reap this overabundance. In medicine, we want human beings to share the beneficial not the detrimental. And when we talk about human beings we mean all human beings; not simply the rich and not simply the adult.

It took a long time to get the child into the obstetrical picture. In the early fifties we enlarged the concept of the American Association for Maternal Welfare to include Child Welfare. Today the good obstetrician no longer doubts that in pregnancy he serves two patients. If he has doubts, the good pediatrician will remind him. And if we do have a defective fetus, it is not his annihilation but his care, cure and rehabilitation which is the mark of the good physician and the road to medical progress.

Intrauterine Battered Child

Let us not be misled by that Latin term fetus. When translated into English all it means is the *young one*, the *young in the womb*, the *unborn offspring*. If we attend to the etymology of infant which means *not to speak*, we can see that the fetus is even more of an infant than the infant; for it can't even cry, or if it could it couldn't be heard. Who is there to speak in defense of this unborn infant but the physician?

If we have joined legislative forces *against* parents to combat the evil of the battered child syndrome, can we support a movement which makes permissive a medical partnership *with* parents which does the opposite—which extends to an earlier age what we forbid at a later age? Can we not see that what is advocated as therapeutic for the mother is hardly therapeutic for the child? After taking up the cudgel against the battered child syndrome are we now going to pick up the curette and replace the extrauterine with the intrauterine battered child syndrome?

Mrs. Sherri Finkbine, of thalidomide fame, frantically raced to get her abortion for she knew that once she felt life, that once quickening took place, she would never be able to go through with it. Aristotle also held the position that abortion before quickening, but not after, was permissible because of the absence of animation and, therefore, the animated soul. But

surely the modern doctor has travelled a long distance from the third century B.C. and the embryology of Aristotle, and beyond the lay person's understanding of when life is present. The word doctor means teacher and a grave teaching job confronts us.

Is Birth Control Abortion?

For this we first of all need honesty—the honesty of Planned Parenthood's pamphlet entitled *Plan Your Children For Health And Happiness*, which in answer to the question "Is birth control an abortion," answers:

"Definitely not. An abortion kills the life of a baby after it has begun. It is dangerous to your life and health. It may make you sterile so that when you want a child you cannot have it."³⁷

And we need the honesty of Dr. Mary Calderone when she said in 1959, "Believe me, I am not for it (indiscriminate abortion) for, aside from the fact that abortion is the taking of a life, I am mindful of what was brought out by our psychiatrists, that in almost every case abortion, whether legal or illegal, is a traumatic experience that may have severe kickbacks later on."³⁸

And secondly, we must profoundly grasp the import of the proposed provision permitting the abortion of an unborn offspring by virtue of a defect. This represents a radical departure from the entire tradition of medicine. It permits a physician to decide, on the basis of his estimate of a defect, who is to live and who is to die. It initiates the beginning of a brand new end of medicine. To the perfective, preventive and curative ends we can now add Exterminative Medicine. Where it will stop no one knows. The lessons of the Nazi era and the Nürnberg trials have obviously not been learned.

Sanctity of Human Life

Perhaps Dr. Joseph DeLee, the former and great University of Chicago Lying-In medical director, the obstetrician whose pioneering work as guardian of maternal life and health catapulted Chicago obstetrics into world leadership, says it best.

He said it in a long editorial note in 1940. His remark is best appreciated in the light of an earlier editorial note that appeared in 1927.

In 1927 he stated bluntly, "The only

thing I have to say about therapeutic abortions is that there are not enough done."³⁹

But appreciation of life becomes sweet with experience and age.

I close with his statement of 1940:

"All doctors (except abortionists) feel that the principles of the sanctity of human life, held since the time of the ancient Jews and Hippocrates and stubbornly defended by the Catholic Church are correct. And we are pained when placed before the necessity of sacrificing it. At the present time, when rivers of blood and tears of innocent men, women and children are flowing in most parts of the world, it seems silly to be contending over the right to live of an unknowable atom of human flesh in the uterus of a woman. No it is not silly. On the contrary, it is of transcendent importance that there be in this chaotic world one high spot, however small, which is against the deluge of immorality that is sweeping over us. That we the medical profession hold to the principle of the sacredness of human life and of the right of the individual even though unborn is proof that humanity is not yet lost and that we may ultimately obtain salvation."⁴⁰

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(Continued on page 751)

Questionnaire Response: Illinois State Medical Society Symposium on Abortion—WFLD—March 15, 1967

Do you think abortions should be allowed when

The Mother's Life Is in Danger?

MALE & FEMALE	Total	A G E			Over 50	Single	M A R I T A L		S T A T U S		
		Under 21	21-35	36-50			Married	Widowed			
ONLY	1013-100.0%	36-100.0%	429-100.0%	335-100.0%	213-100.0%	118-100.0%	837-100.0%	32-100.0%	Divorced	26-100.0%	26-100.0%
Yes	876 86.5%	31 86.1%	358 83.4%	300 89.6%	187 87.8%	97 82.2%	730 87.2%	25 78.1%	24 92.3%	24 92.3%	24 92.3%
No	122 12.0	5 13.9	62 14.5	30 9.0	25 11.7	20 16.9	93 11.2	7 21.9	2 7.7	2 7.7	2 7.7
Depends	8 .8	6 1.4	2 .6	2 .6	1 .5	1 .9	7 .8	1 .3	1 .3	1 .3	1 .3
No Answer	7 .7	3 .7	3 .7	3 .8	1 .5	1 .9	7 .8	1 .3	1 .3	1 .3	1 .3
ONLY	744-100.0%	22-100.0%	334-100.0%	247-100.0%	141-100.0%	81-100.0%	608-100.0%	29-100.0%	Divorced	26-100.0%	26-100.0%
Yes	647 87.0%	20 90.9%	280 83.8%	222 89.9%	125 88.7%	70 86.4%	528 86.8%	25 86.2%	24 92.3%	24 92.3%	24 92.3%
No	88 11.8	2 9.1	48 14.4	22 8.9	16 11.3	11 13.6	71 11.6	4 13.8	2 7.7	2 7.7	2 7.7
Depends	4 .5	3 .9	3 .9	1 .4	1 .5	1 .9	4 .8	1 .3	1 .3	1 .3	1 .3
No Answer	5 .7	3 .9	3 .9	2 .8	1 .5	1 .9	5 .8	1 .3	1 .3	1 .3	1 .3
MALE	269-100.0%	Under 21	21-35	36-50	Over 50	Single	Married	Widowed	Divorced	26-100.0%	26-100.0%
ONLY	14-100.0%	11 78.6%	95-100.0%	88-100.0%	72-100.0%	37-100.0%	229-100.0%	3-100.0%	Divorced	26-100.0%	26-100.0%
Yes	229 85.1%	3 21.4	78 82.1%	78 88.6%	62 86.1%	27 73.0%	202 88.2%	3 100.0%	2 7.7	2 7.7	2 7.7
No	34 12.6	4 1.5	14 14.7	8 9.2	9 12.5	9 24.3	22 9.6	3 100.0%	2 7.7	2 7.7	2 7.7
Depends	4 1.5	3 3.2	3 3.2	1 1.1	1 1.4	1 2.7	3 1.3	1 2.7	1 2.7	1 2.7	1 2.7
No Answer	2 .8	1 .1	1 .1	1 .1	1 .4	1 .9	2 .9	1 .3	1 .3	1 .3	1 .3

Do you think abortions should be allowed when

The Pregnancy Resulted from Rape?

MALE & FEMALE	A G E				M A R I T A L S T A T U S			
	Total	Under 21	21-35	36-50	Over 50	Single	Married	Widowed
Total	1013-100.0%	36-100.0%	429-100.0%	335-100.0%	213-100.0%	118-100.0%	837-100.0%	32-100.0%
Yes	784 77.4%	24 66.7%	315 73.5%	274 81.8%	171 80.3%	80 67.8%	660 78.9%	23 71.9%
No	217 21.4%	12 33.3%	110 25.7%	55 16.4%	40 18.8%	38 32.2%	166 19.8%	9 28.1%
Depends	3 .3	....	1 .2	2 .6	....	....	2 .2	....
No Answer	9 .9	....	3 .6	4 1.2	2 .9	....	9 1.1	....
FEMALE								
ONLY	Total	Under 21	21-35	36-50	Over 50	Single	Married	Widowed
Total	744-100.0%	22-100.0%	334-100.0%	247-100.0%	141-100.0%	81-100.0%	608-100.0%	29-100.0%
Yes	583 78.4%	13 59.1%	248 74.3%	205 83.0%	117 83.0%	55 67.9%	485 79.8%	22 75.9%
No	152 20.4%	9 40.9%	83 24.8%	37 15.0%	23 16.3%	26 32.1%	115 18.9%	7 24.1%
Depends	3 .4	....	1 .3	2 .8	....	....	2 .3	....
No Answer	6 .8	....	2 .6	3 1.2	1 .7	....	6 1.0	....
MALE								
ONLY	Total	Under 21	21-35	36-50	Over 50	Single	Married	Widowed
Total	269-100.0%	14-100.0%	95-100.0%	88-100.0%	72-100.0%	37-100.0%	229-100.0%	3-100.0%
Yes	201 74.7%	11 78.6%	67 70.5%	69 78.4%	54 75.0%	25 67.6%	175 76.4%	1 33.3%
No	65 24.2%	3 21.4%	27 28.4%	18 20.5%	17 23.6%	12 32.4%	51 22.3%	2 66.7%
Depends	....	....	....	....	....	....	....	....
No Answer	3 1.1	....	1 1.1	1 1.1	1 1.4	....	3 1.3	....

Do you think abortions should be allowed when

The Mother's Mental Health Is Threatened?

MALE & FEMALE	A G E				M A R I T A L S T A T U S			
	Total	Under 21	21-35	36-50	Over 50	Single	Married	Widowed
Total	1013-100.0%	36-100.0%	429-100.0%	335-100.0%	213-100.0%	118-100.0%	837-100.0%	32-100.0%
Yes	741 73.1%	22 61.1%	293 68.3%	258 77.0%	168 78.9%	73 61.9%	628 75.0%	20 62.5%
No	253 25.0%	14 38.9%	125 29.2%	72 21.5%	42 19.7%	44 37.3%	193 23.1%	11 34.4%
Depends	9 .9	....	5 1.2	3 .9	2 .9	....	9 1.1	....
No Answer	10 1.0	....	6 1.3	2 .6	2 .9	1 .8	7 .8	1 3.8
FEMALE								
ONLY	Total	Under 21	21-35	36-50	Over 50	Single	Married	Widowed
Total	744-100.0%	22-100.0%	334-100.0%	247-100.0%	141-100.0%	81-100.0%	608-100.0%	29-100.0%
Yes	546 73.4%	12 54.5%	226 67.7%	195 78.9%	113 80.1%	51 63.0%	455 74.8%	20 69.0%
No	183 24.6%	10 45.5%	98 29.3%	50 20.2%	25 17.7%	29 35.8%	141 23.2%	8 27.6%
Depends	7 .9	....	4 1.2	2 .9	1 .7	....	7 1.2	....
No Answer	8 1.1	....	6 1.8	....	2 1.5	1 1.2	5 .8	1 3.4
MALE								
ONLY	Total	Under 21	21-35	36-50	Over 50	Single	Married	Widowed
Total	269-100.0%	14-100.0%	95-100.0%	88-100.0%	72-100.0%	37-100.0%	229-100.0%	3-100.0%
Yes	195 72.5%	10 71.4%	62 65.2%	63 71.6%	55 76.4%	22 59.5%	173 75.5%	....
No	70 26.1%	4 28.6%	32 33.7%	22 25.0%	17 23.6%	15 40.5%	52 22.7%	3-100.0%
Depends	2 .7	....	1 1.1	1 1.1	....	....	2 .9	....
No Answer	2 7	....	....	2 2.3	....	....	2 .9	....

Do you think abortions should be allowed when

The Unborn Baby Is Expected to Be Deformed?

MALE & FEMALE	A G E					M A R I T A L					S T A T U S				
	Total	Under 21	21-35	36-50	Over 50	Single	Married	Widowed	Divorced						
ONLY															
Total	1013-100.0%	36-100.0%	429-100.0%	335-100.0%	213-100.0%	118-100.0%	837-100.0%	32-100.0%	26-100.0%						
Yes	725 71.6%	23 63.9%	283 66.0%	255 76.1%	164 77.0%	75 63.6%	610 72.9%	22 68.8%	18 69.2%						
No	281 27.7	13 36.1	143 33.3	78 23.3	47 22.0	42 35.6	222 26.5	10 31.2	7 27.0						
Depends	7 .7	.....	3 .9	2 .6	2 1.0	1 .8	5 .6	.....	1 3.8					
No Answer	.....	.....	.....	.....	.....	.....	.....	.....	.....
FEMALE															
ONLY															
Total	744-100.0%	22-100.0%	334-100.0%	247-100.0%	141-100.0%	81-100.0%	608-100.0%	29-100.0%	26-100.0%						
Yes	541 72.7%	13 59.1%	222 66.5%	194 78.5%	112 79.4%	56 69.1%	446 73.4%	21 72.4%	18 69.2%						
No	197 26.5	9 40.9	110 32.9	51 20.6	27 19.1	25 30.9	157 25.8	8 27.6	7 26.9						
Depends	6 .8	.....	2 .6	2 .9	2 1.5	.....	5 .8	.....	1 3.9					
No Answer	.....	.....	.....	.....	.....	.....	.....	.....	.....
MALE															
ONLY															
Total	269-100.0%	Under 21	21-35	36-50	72-100.0%	37-100.0%	229-100.0%	3-100.0%	.....					
Yes	184 68.4%	14-100.0%	95-100.0%	88-100.0%	52 72.2%	19 51.4%	164 71.6%	1 33.3%	.....					
No	84 31.2	4 28.6	33 34.7	27 30.7	20 27.8	17 45.9	65 28.4	2 66.7	.....					
Depends	1 .4	.....	1 1.1	.....	.....	1 2.7	.....	.....	.....			
No Answer	.....	.....	.....	.....	.....	.....	.....	.....	.....

Do you think that

All Abortions Should Be Prohibited?

MALE & FEMALE	A G E					M A R I T A L					S T A T U S				
	Total	Under 21	21-35	36-50	Over 50	Single	Married	Widowed	Divorced						
ONLY															
Total	1013-100.0%	36-100.0%	429-100.0%	335-100.0%	213-100.0%	118-100.0%	837-100.0%	32-100.0%	26-100.0%						
Yes	100 9.9%	5 13.9%	53 12.4%	19 5.7%	23 10.8%	18 15.2%	73 8.7%	6 18.8%	3 11.5%						
No	913 90.1	31 86.1	376 87.6	316 94.3	190 89.2	100 84.8	764 91.3	26 81.2	23 88.5						
Depends	.....	.....	.....	.....	.....	.....	.....	.....	.....
No Answer	.....	.....	.....	.....	.....	.....	.....	.....	.....
FEMALE															
ONLY															
Total	744-100.0%	Under 21	21-35	36-50	141-100.0%	81-100.0%	608-100.0%	29-100.0%	26-100.0%						
Yes	73 9.8%	5 22.7%	44 13.2%	12 4.9%	12 8.5%	11 13.6%	54 .9%	5 14.3%	3 11.5%						
No	671 90.2	17 77.3	290 86.8	235 95.1	129 91.5	70 86.4	554 91.1	24 85.7	23 88.5						
Depends	.....	.....	.....	.....	.....	.....	.....	.....	.....
No Answer	.....	.....	.....	.....	.....	.....	.....	.....	.....
MALE															
ONLY															
Total	269-100.0%	Under 21	21-35	36-50	72-100.0%	37-100.0%	229-100.0%	3-100.0%	.....					
Yes	27 10.0%	14-100.0%	95-100.0%	88-100.0%	52 72.2%	19 51.4%	164 71.6%	1 33.3%	.....					
No	242 90.0	.....	9 9.5%	7 8.0%	11 15.3%	7 18.9%	19 8.3%	1 33.3%	.....					
Depends	.....	.....	86 90.5	81 92.0	61 84.7	30 81.1	210 91.7	2 66.7	.....					
No Answer	.....	.....	.....	.....	.....	.....	.....	.....	.....

Current Abortion Laws

By B. J. GEORGE, JR.

Professor of Law, University of Michigan

It is evident, if from nothing else than the sheer bulk of material extant, that none of the three great sister professions, medicine, law and theology, has had an easy time determining its official attitude toward abortion. It is doubtful that they have ever completely shared the same conclusion, and unlikely that they will come to do so now. At best, members of each profession can come to understand, if not to agree with, the principles and values important to those in the other disciplines. My task is to delineate for you the legal doctrines affecting abortion.¹

First, however, it is well to break down the problem into some of its component parts. We may be concerned with the qualifications of the person who performs the abortion; it makes a difference whether the actor is a layman or a physician and, if he is a physician, whether he performs the operation in or out of a hospital. We are concerned about the pregnant woman; we would condemn non-consensual abortion in most if not all circumstances. We also need to know whether other persons have helped her arrange for the abortion and whether, if they have a legal relationship to the patient, they have expressly or impliedly agreed to the operation. We are especially interested in the reasons underlying the request to be aborted. Is the woman's life in danger? Is her mental or physical health adversely affected by the pregnancy? Is there a likelihood, whatever the reason, that the fetus might be born physically or mentally defective? Did conception occur through an act legally to be labeled as rape or incest? Did conception take place in or out of wedlock? Are there other siblings in the family, whether the family is founded on legal marriage or a *de facto* relationship, who will be adversely affected by the advent of a new child, whether the deprivation is in terms of maternal care or of family finances? Is there an absence of any

of these considerations, but nonetheless a strong desire on the part of the woman to be aborted?

Abortion at Common Law

The common law, *i.e.*, the judicially-created law developed case by case in England, resolved very few of these problems. Apparently it was a crime, at the misdemeanor level, to commit an abortion if the fetus had quickened. If there was no quickening, abortion was not a crime. Granted the state of medical knowledge at the time, this doctrine would have had very little impact on the medical profession. Nor is it likely that the ecclesiastical courts that lingered on in England after the Reformation concerned themselves with abortion. Whatever the present posture of Catholic and Protestant theologians may be on the issue of the doctrinal propriety of abortion, the evidence is substantial that Roman Catholic dogma assumed its present form only in the nineteenth or early twentieth century and that no clear consensus has ever been reached within Protestantism.² At most, therefore, religious doctrines corresponded to the common law position that quickening was required. Accordingly, there is no relevant case authority coming out of the English ecclesiastical courts prior to their abolition.

Statutory Prohibition of Abortion

The law governing abortion, therefore, is exclusively statutory and relatively modern. There are criminal statutes prohibiting abortion in all of our states. The primary question is whether there are exceptions in the statutory language that run in favor of medically-performed abortions. Four of the statutes³ contain no exception whatever to the absolute prohibition against abortion. In recent years, however, the courts in two of these states have read in an exception in favor of some therapeutic abortions; the Massachusetts Supreme Judicial

Court has exempted a physician who acts in the honest belief that the operation is necessary to save the woman from great peril to her life or health,⁴ and the New Jersey Supreme Court has permitted an abortion to preserve the pregnant woman's life, though not an abortion for any other medical purpose.⁵

All of the other states have specifically provided an exception for abortions necessary to preserve the life of the mother. It has been argued that the original intent of this legislation was to exempt all medical practitioners from the coverage of abortion laws and to reach only laymen, because abortion was a radical enough technique that medical doctors performed it only when they thought it necessary to preserve the woman's life; in short, the statute merely codified existing medical practices.⁶ Whether that is so or not, as medical indications for abortion extended beyond the sphere of protection of life, the statutes clearly became restrictive upon and not supportive of medical practice, and no abortion that could not be predicated on the necessity to preserve the mother's life could be called lawful. Because it is rarely necessary today to operate to preserve the mother's life either for physiological or psychological reasons, one can safely assert that all but a very small number of the abortions performed each year in the United States are technically illegal.

Abortion laws, however, are typical of most laws directed at the control of sexual and sexually-related activities. The sweeping proclamation reinforces the moral abstraction to which most of our people give nominal adherence, but in practice these laws remain for the most part unenforced so that our prevalent practices continue untouched by official interference. This is very much true of abortions performed by licensed physicians in hospitals. Only one reported appellate case involves a prosecution of a doctor who has performed an abortion under such circumstances, and that was decided in the doctor's favor.⁷ It is for this reason that the action of the California State Board of Medical Examiners in citing several San Francisco physicians for "unprofessional conduct" for having performed therapeutic abortions in hospitals on patients who had contracted rubella in the first trimester of pregnancy produced such evident shock waves in the medical fratern-

nity, and considerable discomfort in legal circles as well.⁸

Procedural Problems

There are two problems that could arise if a physician were prosecuted for an abortion that he performed with approval of his hospital confreres. One is whether the circumstances asserted as justifying the abortion must exist as an objective fact, or whether a good faith, or perhaps a "reasonable" good faith belief that the operation is necessary is sufficient. In form the latter test is more favorable to the physician; whether in fact it is so depends in turn on whether other medical experts can be obtained to testify on behalf of the state that the abortion was not objectively necessary.

The second is the question of where the burden of proof of justification lies. Though this is usually considered a lawyer's problem, it has very great significance to the defendant, for the determination of where the burden of proof lies often determines the outcome of the case itself. If the prosecution has the burden of proving that the operation was not objectively necessary, or not in good faith believed to be necessary, as the case may be, it will probably be difficult for it to discharge that burden, if for no other reason than that medical doctors are reluctant to become witnesses for the state under circumstances like these. If, however, the burden is on the defendant doctor to prove the justifiability, he may have difficulty in finding colleagues to come to his defense. The relevant provision of the Illinois Criminal Code, § 23-1 (b), clearly embodies the latter test, which means a more restrictive law, from the physician's point of view, than is encountered in most American states.

Therapeutic Abortion

Only four jurisdictions have significantly broader language in their statutes. Colorado and New Mexico permit abortions necessary to prevent "serious and permanent bodily injury," while Alabama and The District of Columbia authorize an abortion to protect the life or health of the mother. What these terms mean is uncertain, because there is the same dearth of prosecutions of doctors in these jurisdictions that is evident in the states with the more limited exceptions. No statute cur-

rently legitimates abortions dictated by eugenic, humanitarian or socio-economic considerations.^{8a}

Attempted Abortion

Under some of the older statutes there might be no criminality if the woman were not in fact pregnant or if, though pregnant, she failed to miscarry. The reason was found in certain technical doctrines in the law of attempt that need not concern us here. Most of the modern statutes eliminate this problem by defining the crime of abortion as the use of instruments, the administration of drugs or the use of any other means intended to produce an abortion, and by using the term "any woman" or "a woman whether pregnant or not." The Illinois Criminal Code, § 23-a (a), expressly provides that "it shall not be necessary in order to commit abortion that such woman be pregnant or, if pregnant, that a miscarriage be in fact accomplished."

Criminality of the Pregnant Woman

Under most state statutes the woman is not considered a criminal even though she has sought out the abortionist. This makes functional sense, because she cannot assert the privilege against self-incrimination if she is called to testify against the defendant. In some of the minority jurisdictions in which she is viewed as an accomplice of the abortionist, it has been necessary to pass immunity legislation in order to obtain the needed testimony. The woman's husband, paramour, relative or friend who arranges the abortion is, however, legally an accomplice and can be prosecuted. In fact, though, prosecutions of persons like this are rare.

Traffic in Abortifacients

Activities other than the abortion itself are also commonly criminal. It is a crime to advertise the availability of abortifacients in a majority of states; the same statutes usually prohibit the distribution of abortifacients as well. The original legislative motive is fairly clear from the usual context in which these provisions are found—the obscene literature statute. There are no appellate decisions interpreting them, but from the fate of the statutes prohibiting traffic in contraceptives it is quite clear that they would be construed

not to apply to distribution of drugs or instruments in regular medical supply channels.⁹

License Revocation

The criminal law is not a particularly efficient means of enforcement in areas like abortion, at least as far as licensed physicians and hospitals are concerned. The most efficient means are through licensing statutes. The overwhelming majority of states makes the performance of a criminal abortion a basis for the revocation of a license to practice medicine, and in the rest of the states abortion either is viewed as one application of the more general term "unprofessional conduct," or else revocation may be based on "conviction of a felony" which includes abortion. Usually it is the criminal law that determines whether the abortion is lawful or not. However, three states, Alabama, Louisiana and Oregon, have spelled out in their licensing laws the procedures to be followed in receiving authorization to perform a therapeutic abortion. The Oregon Supreme Court has held that the specific provisions in the licensing law control the more general provisions of the criminal law, so that compliance with the licensing law eliminates any possibility of prosecution.¹⁰

Civil Liability

A word might also be said about the doctor's civil responsibility for performing an abortion. A few states have denied to the woman or her survivors any power to sue for a bungled abortion, on the ground that the transaction was illegal and thus not subject to redress. In most instances, however, the same standards of malpractice apply to an abortion as apply to any other medical technique, so that the doctor is civilly liable if he is negligent—but only if he is negligent. Revision of the abortion laws to exempt licensed physicians performing abortions in licensed hospitals would neither increase nor decrease the physician's malpractice liability.

Reform Legislation

This, then, is the state of current law. It is not my assignment in this Symposium to advocate either change in or retention of the statutes now in force. However, it is in order to indicate the fact that efforts have been made in several states to liberalize the

law of abortion, though to date without success, except in Colorado. Much of the impetus for these efforts came from the drafting and adoption by The American Law Institute of its Model Penal Code. Section 230.3 of the Code exempts abortions performed by a licensed physician for any of three grounds: (a) that continuation of the pregnancy would gravely impair the physical or mental health of the mother; (b) that the child would be born with a grave physical or mental defect; and (c) that the pregnancy resulted from rape, incest or felonious intercourse, the latter being the functional equivalent to statutory rape in existing law. It thus recognizes therapeutic, eugenic and humanitarian, but not socioeconomic grounds for legalized abortion.

The originally proposed Illinois Criminal Code contained substantially the same provisions as the Model Penal Code, but in the Legislature the decision was reached to continue the older, more restrictive provision. This Symposium is in a sense the result of that legislative decision. In Minnesota the drafters also recommended enactment of the equivalent to the Model Penal Code, but the Minnesota Legislature struck the whole of the chapter on sex offenses and re-enacted the existing law, including the limited exemption in the abortion statute. In New York, efforts at liberalization failed in the early drafting state, and similar failure is reported in New Hampshire.

In California, attempts have been made to add a Humane Abortion Law to the Health and Safety Code and to amend the Penal Code to exempt abortions performed in compliance with that law, but in each session the bill has failed of passage.¹¹

Thus, on the basis of experience to date, it would appear that liberalization is not feasible. Nevertheless, it should be recognized that the pressures for a revision of the law are markedly increasing. There is now an almost continuous stream of articles and editorials in newspapers and popular magazines, as well as in professional journals, on the abortion problem, and the majority of these writings favor at the minimum the legalization of therapeutic abortions. The high incidence of abortions is also more and more an acknowledged fact. In short, I see here the same ferment that is evident in the field of family law in general, and that was evident

a few years ago concerning dissemination of contraceptives and in several matters of constitutional law like segregation and the right to counsel. Ferment of this magnitude usually produces change either through legislation or through altered judicial interpretations of constitution or statute.

Constitutional Considerations

Is it likely that the courts will intervene? Those who argue that there is a constitutional objection to the invocation of the abortion statute against a physician who performs a therapeutic or eugenic abortion base their argument on the recent case of *Griswold v. Connecticut*,¹² which voided the Connecticut statute prohibiting dissemination of contraceptives, at least to married couples. In particular, Mr. Zad Leavy, an attorney, and Dr. Jerome M. Kummer compare the traditional abortion law and the Connecticut contraceptives statutes and conclude:

- (1) Both statutes are at war with currently accepted standards of medical practice; (2) both statutes invade the sacred realm of marital privacy by denying married couples the right to plan the future of their family; (3) both statutes force the birth of deformed children, or leave abstinence as the alternative; (4) both statutes are largely unenforced, nevertheless prosecution hangs like a cloud over the medical profession; (5) both statutes result in discrimination against people in lower economic brackets; (6) both statutes are in conflict with one of the world's most critical problems today, the population explosion; (7) both statutes involve the imposition of a religious principle on the entire community by government sanction.¹³

Substantially the same arguments are also being advanced by Mr. Leavy and Professor Herman Hill Kay of Berkeley in their *amicus curiae* brief in the case now pending in the California Supreme Court, *Shively v. Stewart*.¹⁴ The *Griswold* case, however, is so divided in its rationale and so limited in its holding on the matter of contraception itself, that it seems unlikely to me that a constitutional attack on the abortion statute will be successful at this time.

A more promising alternative in those states with nineteenth-century statutes that have remained uninterpreted since their enactment is to argue that the original legislative intent was to exclude legitimate medical practices from the coverage of the criminal abortion law, and that the expanded modern concept of therapeutic abortion should be read into the statute by judicial

interpretation even though the literal language of the statute refers to "life of the mother" only.¹⁵ This, however, would require a greater manipulation of legislative language than a modern court is likely to exercise, and would be clearly out of the question in a state like Illinois in which the legislature has recently considered the abortion problem and deliberately chosen a restrictive provision. It is my prediction, therefore, that liberalization will not be achieved through new judicial decisions, but only through new legislation that will be passed when the popular pressures for reform become strong enough.

Control by Administrative Regulation

I would like to inject one additional *caveat*, concerning the technique of drafting reform legislation. This is of course of interest only to one who favors revision of the traditional law. Some efforts have been made to provide in the criminal statute itself for consultation with colleagues, approval by hospital committees, and the like. This is an undesirable legislative technique. It may be that these procedures will prove cumbersome or ineffective, or that other procedures will be developed that will be equally effective. If there is to be change under those circumstances, it will have to be through further amendment of the criminal code provision. This is not easy to

achieve, and there is always the danger that a voice vote by a runaway legislature may result in retrogression to the older form of statute. Some of this can be avoided by amending the licensing statutes to provide for specific procedures, and simply exempting from the criminal abortion statute any abortion performed by a licensed physician in a licensed hospital "in the belief" that it is necessary for therapeutic, eugenic or humanitarian reasons. A civil statute perhaps can be amended more readily, and more safely, than a criminal code. But the best method, I submit, is to control therapeutic abortion practices by administrative regulations. These can be changed simply, and more important, are essentially within the control of the medical profession itself. In many states the present statutes creating a State Department of Health or a State Board of Medical Examiners are broad enough to authorize the promulgation of new regulations on therapeutic abortion. If the criminal code provision is amended as I have suggested, there should be no legal objection to proceeding immediately to draft and promulgate new regulations governing the details of therapeutic abortion practice by physicians in hospitals. In this way abortion can be restored to the context in which I think it belongs—the realm of medical practice unhampered by the criminal law.

References

1. A more complete survey of the present law is contained in George, *Current Abortion Laws: Proposals and Movements for Reform*, 17 Western Reserve Law Review 371 (1965); the article is part of a Symposium on Abortion and the Law. Other legal articles that should be consulted are Leavy & Kummer, *Abortion and the Population Crisis; Therapeutic Abortion and the Law*; *Some New Approaches*, 27 Ohio State Law Journal 647 (1966); Leavy & Kummer, *Criminal Abortion: Human Hardship and Unyielding Laws*, 35 Southern California Law Review 123 (1962); Packer & Gampell, *Therapeutic Abortion: A Problem in Law and Medicine*, 11 Stanford Law Review 417 (1959); Quay, *Justifiable Abortion—Medical and Legal Foundations*, 49 Georgetown Law Journal 395 (1961); Sands, *The Therapeutic Abortion Act: An Answer to the Opposition*, 13 University of California at Los Angeles Law Review 285 (1966).
2. Kinsolving: *What About Therapeutic Abortion?*, The Christian Century, May 13, 1964, pp. 632-33.
3. In Louisiana, Massachusetts, New Jersey and Pennsylvania.
4. *Commonwealth v. Brunelle*, 341 Mass. 675, 171 N.E. 2d 850 (1961).
5. *State vs. Brandenburg*, 137 N.J.L. 124, 58 A.2d 709 (1948).
6. Leavy & Kummer: *Abortion and the Population Crisis; Therapeutic Abortion and the Law; Some New Approaches*, 27 Ohio State Law Journal 647 at 669-71 (1966).
7. *State v. Buck*, 200 Ore. 87, 262 P.2d 495 (1953). The doctor had complied with the therapeutic abortion procedures set out in the medical licensing statute, and the Oregon Supreme Court held that the licensing provisions superseded the criminal statute.
8. An action to enjoin the Board from proceeding is now pending in the California Supreme Court under the case name of *Shively v. Stewart*. See the editorial, *Abortion and the Law*, 199 Journal of the American Medical Association, No. 3, pp. 179-80, January 16, 1967.
- 8a. Governor Love of Colorado signed into law on April 25, 1967, a bill incorporating in substance the provisions of the Model Penal Code. The statute provides for consultation with other doctors, and requires that the abortion be performed by a licensed physician in a hospital facility.
9. *Youngs Rubber Corp. v. C. I. Lee & Co.*, 45 F.2d 103 (2d Cir. 1930).
10. *State v. Buck*, 200 Ore. 87, 262 P.2d 495 (1953).
11. See Sands, *The Therapeutic Abortion Act: An Answer to the Opposition*, 13 University of California at Los Angeles Law Review 285 (1966).
12. 381 U.S. 479 (1965).
13. *Op. cit. supra* note 6 at 674.
14. *Amicus curiae* brief at p. 25
15. See *supra* note 6.

Conference on Rubella

*Presented by the Illinois Society for Microbiology
February 4, 1967, at Loyola University, Chicago*

THE EPIDEMIOLOGY OF RUBELLA

By JOHN L. SEVER, M.D., PH.D.

The epidemic of rubella 25 years ago in Australia resulted in the first recognition of the significance of this infection as a cause of defective children. It was following this epidemic that the ophthalmologist S. Norman Gregg noted a high frequency of cataracts in children and recognized the association between rubella in the first trimester of pregnancy and damage to the eye. Since that time a number of studies have confirmed and extended these observations. The frequency of abnormal pregnancy outcomes is approximately 50 percent if rubella occurs in the first month of pregnancy, 22 percent if it occurs in the second month of pregnancy, and 6 percent if it occurs in the third month of pregnancy. In addition to the malformations of the eyes, heart, deafness, microcephaly, and mental retardation, in the last few years we have become aware that congenital rubella may also result in hepatosplenomegaly, thrombocytopenia, jaundice, pneumonitis, radiolucency of the long bones, and chronic infection during the new born period.

Epidemic Cycles

Rubella occurs primarily in the spring of the year in most countries. Epidemics generally occur at intervals of about seven years. Some of the largest epidemics have coincided with periods of military mobilization. The majority of infections occur in children under 15 years of age and most of these are among school age children. Rubella is less communicable than rubeola or varicella, and populations in semi-isolated areas frequently show a high proportion of susceptibles, and may experience extensive epidemics at infrequent intervals. There is

considerable variation in the reporting of rubella among different countries and cities. This is mainly due to the mildness of the disease produced by the virus and the fact that in most areas rubella is not a reportable infection.

In the United States data from the Communicable Disease Center since 1955 has been analyzed. Significant epidemics were noted in 1958 and in 1964-1965. In the 1964-1965 epidemic there was a clear movement of the epidemic from the Northeast to the West and South. For the most part the epidemic did not involve the west coast of the United States, Hawaii, and Puerto Rico until 1965 and was more intense in 1964 than in 1965.

The intensity and effect of the 1964 epidemic on pregnant women in the United States was studied by 11 institutions participating in the prospective Collaborative Study of Cerebral Palsy. In the study detailed clinical data were obtained for 6,161 pregnant patients and their children and serial serum specimens taken throughout pregnancy were subsequently tested for antibody to rubella. Data available now from this study indicate that of the 6,161 pregnant women under study, 10 percent were exposed during the first trimester and 26 percent during the second and third trimester. Two percent of the women developed clinical rubella, 40 percent of those in the first trimester. Ten percent of the women with clinical rubella in the first trimester had a child with congenital rubella syndrome which was recognized within the first month after birth. Clinical rubella was more frequent among white patients. Non-household exposures were as likely as household exposures to lead to clinical rubella. Serological data corroborated the diagnosis of clinical rubella in 74 percent of the cases tested. Inapparent infection occurred in 6 percent of the women studied who were exposed to rubella in the

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first trimester of pregnancy but did not develop clinical disease.

Studies in military populations in the United States have further substantiated the seasonal occurrence of rubella. In general, rubella occurs among recruits primarily in the spring. For the recruit training centers in the United States, the one at Fort Ord, Cal., consistently reports more rubella than any other training station. Peak years for rubella at Fort Ord were 1955, 1958-1959, and 1964-1965. The overall rate of rubella reported in military recruits in this country is 18 per thousand per year. One of the factors unique to Fort Ord is the high frequency of rubella among individuals from Hawaii. In 1960, for example, 77 percent of the recruits from Hawaii had rubella while at Fort Ord. The high frequency among recruits from other western states varied between 5 percent and 20 percent. Thus rubella occurs rather frequently among military recruits, particularly at Fort Ord, and is of concern in military recruit training programs.

Susceptibility—Spread of Infections

The epidemiology of rubella is undoubtedly influenced by the susceptibility of the population. This susceptibility can be determined by serological studies of the frequency of antibody among individuals.

In a serological study of 268 individuals, who were in the general population of Montgomery County Md., in 1957, the frequency of antibody to rubella was determined. The frequency of rubella antibody increased from approximately 35 percent among children 1-10 years of age to 85 percent in the age group 16-25 years and older. This indicates that approximately 15 percent of the adults sampled were susceptible to infection with rubella. The major acquisition of rubella antibody occurred among school age children and this was several years later than that of rubeola antibody. In all ages, the frequency of rubella antibody was consistently less than that for rubeola.

In studies of pregnant women we have found that the frequency of women without antibody to rubella in the continental United States has varied between 19 to 32 percent in 11 collaborating study hospitals. There was a significantly greater frequency of individuals without neutralizing antibody among pregnant Negroes as compared to white patients and the number of women without antibody decreased significantly with increasing age of the patients. There was no correlation between the reported history of rubella and the presence or absence of antibody.

(Continued on page 703)

Abstract **CLINICAL MANIFESTATIONS OF RUBELLA** **AND THE RUBELLA SYNDROME**

By LOUIS Z. COOPER, M.D.

The availability of viral isolation and serologic techniques for diagnosis of rubella, coupled with the enormous number of patients with rubella during the 1964 epidemic, provided an unparalleled opportunity for study of the natural history of this infection. Carefully controlled observation of rubella in children characterized the duration of virus excretion in the pharynx, and viremia, and the antibody response. This usually benign illness is rarely complicated by symptomatic thrombocytopenic purpura or encephalitis. An

uncomfortable, but self-limiting arthritis is not an uncommon complication in adults.

In contrast, rubella acquired in utero may produce a chronic infection extending from early fetal life until months after birth, and a variety of congenital anomalies. Heart disease, cataract, deafness, and retardation are most common. This presentation will describe clinical virologic and immunologic data accumulated at New York University Medical Center in the Rubella Birth Defect Evaluation Project in study of more than 300 infants with congenital rubella who were born after the 1964 epidemic. The sharp contrasts between this illness and postnatal rubella will be emphasized.

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Abstract

TECHNIQUES AVAILABLE FOR THE DIAGNOSIS OF RUBELLA INFECTIONS

By DAVID A. FUCCILLO, PH.D.

Since the first description by Parkman, et. al., Sever, et. al., and Weller and Neva in 1962 of the propagation of rubella virus in primary African green monkey kidney (AGMK) and primary human amnion tissues a number of reports have appeared dealing with the successful propagation of rubella in both primary cell cultures and continuous cell lines.

At present the most sensitive system for the primary isolation of rubella is the AGMK viral interference test. Although the virus does not produce cytopathic change in this tissue, it does produce resistance to challenge by Echo II or Cocksackie A-9. The test requires 10 to 14 days for the completion of one passage.

Four methods are now available for the quantitative measurement of rubella antibody in human and animal sera. These are:

Head, Unit on Perinatal Studies, Section on Infectious Diseases, Perinatal Research Branch, National Institute of Neurological Diseases and Blindness, National Institutes of Health, Bethesda, Md.

(a) the neutralization test, (b) the fluorescent antibody test, (c) the hemagglutination inhibition (HAI) test, and (d) the complement fixation test. The first three tests probably measure the same antibody. This antibody appears 12 to 18 days after exposure to rubella (at the time of rash) and persists for life. For speed and ease of performance, the technique of choice for demonstrating rubella neutralizing antibody is the hemagglutination inhibition test. The complement fixation test detects antibody appearing three to seven days later than the neutralization antibody. Complement fixation serum titers persist for several years but decrease until they are no longer detectable in 50 percent of the cases in 10 to 20 years. The CF test is useful for routine serological diagnosis of rubella in those cases where the patient experienced a rash several days before consulting a physician. It may also be useful in detecting congenitally infected children. A relatively simple process for CF antigen production in BHK-21 cell line is now possible.

Epidemiology of Rubella

(Continued from page 702)

In Hawaii, the frequency of pregnant women without antibody was considerably higher than the groups studied in the continental United States. At the Kaiser Hospital in Honolulu, 58 percent of the women tested did not have neutralizing antibody and in a similar group of pregnant women studied in Hilo, Hawaii, 71 percent did not have antibody. Our recent studies in southern Japan indicate that in the population studied, 34 percent of the pregnant women did not have neutralizing antibody.

Studies of isolated populations have indicated that when rubella occurs in these groups almost all susceptible individuals become infected. In an epidemic we have monitored on the Pribiloff Islands off the coast of Alaska, for example, almost all the individuals over 19 years of age had neutral-

izing antibody, whereas almost none of those under that age had antibody. When rubella was brought to the island by several girls returning from the mainland, the epidemic involved almost every individual under 19 years of age.

Summary

Tremendous fetal damage is caused by rubella and particularly epidemics of rubella. Rubella occurs primarily in the spring of the year and epidemics generally occur every seven years. Based on past epidemic cycles, the next major epidemic in the U.S. may be expected as early as 1970 or 1971. It is obvious that intensive programs are necessary to develop successful vaccines so that rubella may be prevented.

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Illinois Nurses Gain Dramatic Salary Hikes

Salaries for registered nurses working in Illinois hospitals increased dramatically in the six-month period ending last Dec. 31. An Illinois Hospital Association survey shows that the average starting salary for a general duty nurse increased 16 percent—from \$398 to \$462 a month—in that period. Compared to 18 months ago, the average starting salary for general duty nurses has increased by \$89 a month. Corresponding increases were noted for nurses doing other than general duty. The IHA termed the six-month increase “extraordinary and without precedent” and noted that nurses’ salaries are now competitive with other fields. This fact, IHA said, should be used “affirmatively and aggressively in recruiting young people into nursing.”

ISMS Studying New DVR Payment Plan

The ISMS Committee on Usual and Customary Fees is taking a questioning look at the “Fee Ceiling Plan” initiated March 1 by the Illinois Division of Vocational Rehabilitation. Dr. Philip Thomsen, committee chairman, noted that ISMS was not consulted on the plan, and that the plan itself is contrary to fee guidelines established by the state medical society. Dr. Emmet Pearson, DVR medical consultant, has said the plan was initiated upon advice of DVR’s “Statewide Medical Advisory Committee of Practicing Physicians.” A meeting has been scheduled between ISMS and DVR to resolve the problem.

Blanket Assignments OK for Long Term Care

You can obtain a blanket assignment of benefits from a Medicare patient whose condition will need treatment over an extended period of time. How? The patient signs a statement naming you as his physician and designating the time period to be covered by the assignment. The statement is attached to SSA Form 1490 when you submit a claim for payment to the Part B Medicare carrier. The patient must sign the first claim form, but on subsequent claims you need only to indicate—in the patient signature space—that “This is a continuation of a course of treatment for which patient’s assignment was previously obtained.”

Credit Card Insurance Growing in Popularity

Does the thought of losing your credit cards make you quake? Some 60,000 people have their cards lost or stolen every year—but you can protect yourself through insurance. Some credit card companies offer their own insurance at a cost of from \$2 to \$7 a year. These policies

(Continued on page 750)

A Guide to MEDICARE—PUBLIC AID CLAIMS FORMS

by

**The Division of Public Relations and Economics
Illinois State Medical Society**

Delayed payment for service to beneficiaries of government medical programs often results from failure to complete claims forms correctly. The physician's best insurance against such delay—and against having his claim challenged—is to provide a full report of his services. The following pages explain the correct way to fill out claims forms for three categories of patients—Medicare recipients, Illinois Public Aid recipients and patients eligible for both Medicare and Public Aid assistance.

Physicians treating patients eligible for both public aid and Medicare benefits must complete—in duplicate—Form SSA 1490, reproduced on the adjacent page. One copy goes to the Medicare carrier serving your county. The other goes to the Illinois Department of Public Aid (IDPA), 618 E. Washington St., Springfield 62706.

Requirements for filing a claim for Medicare-public aid patients differ from those for Medicare patients in three ways:

- * You must list the patient's complete public aid case identification number.

- * You must code your services, using the proper code number from AMA's *Current Procedural Terminology*.

- * You must list your AMA medical education number.

Following is a step-by-step explanation for completing a claim form for Medicare-public aid recipients.

1. **NAME OF BENEFICIARY**—Record the patient's name as it appears on his red, white, and blue Health Insurance identification card.
2. **CLAIM NUMBER AND SEX**—Record the patient's claim number and sex from his Health Insurance card. Please note: The claim number is NOT the same as the patient's social security number.
3. **PUBLIC AID CASE NUMBER**—Record—in the space indicated by the arrow—the patient's public aid case number as listed on his green IDPA identification card. Listing of the case number tells the Medicare carrier to send an explanation of benefits to both IDPA and the physician. IDPA may then complete the claims processing and assume its responsibility for the \$50 deductible and the 20 percent co-insurance.
4. **CLAIMS INFORMATION**—Your patient's signature is required. Unlike other public aid programs, your patient must make an assignment of benefits and sign the form. His address should also be listed in the designated space.
5. **DATE OF EACH SERVICE**—Dates for intermittent services must be recorded individually. However, routine daily visits over a consecutive number of days may be grouped in one inclusive charge in this manner, "December 1-14." Indicate the number of visits and your charge per visit under Item 7. A visit involving more than routine service must be listed separately in the date column and that service must be explained separately under Item 7. If your charge for an initial visit is higher than for subsequent visits, list the initial visit separately in the date column.
6. **PLACE OF SERVICE**—Use the letter sym-

bols listed at the bottom of the form to indicate where the service was provided.

7. **SURGICAL OR MEDICAL PROCEDURES, SERVICES AND SUPPLIES**—Describe fully the services and/or supplies furnished on each date. If, under Item 5, you listed several visits as one inclusive charge, indicate your charge per visit and the number of visits here. If laboratory service is a part of your charge, do *not* name the laboratory furnishing the service. If services were provided in a place other than the locations listed at the bottom of the page, specify the location.

8. **NATURE OF ILLNESS OR INJURY**—Describe fully the diagnosis of the patient's ailment. Include a description of other conditions which may have complicated treatment.

9. **CHARGES**—List your usual and customary charge for each service performed. List the charges for injectables and dispensed drugs here. If, under Item 5, you listed several visits as one inclusive charge, indicate the total charge for these visits here. For multiple surgical procedures, list the charge for the major surgical procedure unless a separate charge is necessary. Other procedures incidental to the major surgical procedure should be described under Item 7 even if no additional charge is made.

Please note: If, for whatever reason, your charge is less than it is normally for a particular service, it is important that you indicate this on the claim form. Otherwise, the lower charge will be recorded in your fee profile as your usual charge for that service.

10. **PROCEDURE CODES**—List the code number for each procedure performed, using the AMA's *Current Procedural Terminology*. Injectables and dispensed drugs do not require a code number. List the code number for each laboratory procedure for which you are charging. For multiple surgical procedures list the procedure code number for each procedure for which you charge. For each procedure code, injectable, and dispensed drug, there must be a charge or "no charge" notation listed under Item 9.

11. **TOTAL CHARGES**—This is the sum of all charges listed under Item 9.

12. **AMOUNT PAID**—List any payments received from the patient, from whatever source.

13. **UNPAID BALANCE DUE**—The amount entered here is the difference between your total charge and the amount of payment which you have received from the patient.

14. **PHYSICIAN'S NAME AND MEDICAL EDUCATION NUMBER**—List your name and business office address. Then, *list your medical education number immediately after your name.*

(Continued on page 708)

REQUEST FOR PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(Type or Print all Information)

Form Approved.
Budget Bureau No. 72-R730

Copy from your HEALTH INSURANCE CARD	NAME OF BENEFICIARY (Patient) 1
	CLAIM NUMBER 2 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT. **3** →

Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes it below)

Is your illness or injury connected with your employment? ☐ YES ☐ NO Are you attaching itemized receipts for bills? ☐ YES ☐ NO

ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier? ☐ YES ☐ NO
AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other reproduction of this authorization to be used in place of original.

REQUEST FOR PAYMENT: I am requesting payment be made to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the charges.

SIGNATURE (Patient or authorized representative)	DATE SIGNED
ADDRESS (Street address, City, State, ZIP Code)	TELEPHONE NUMBER

REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

B. PLACE OF SERVICE	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Leave Blank
6	7	8	\$ 9	10

NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City, State, ZIP Code) 14	TELEPHONE NUMBER 15	9. Total Charges \$ 11
	CODE NO. 16	10. Amount Paid \$ 12
		11. Any Unpaid Balance Due \$ 13

ASSIGNMENT OF PATIENT'S BILL (Reverse) 17	<input type="checkbox"/> I ACCEPT ASSIGNMENT <input type="checkbox"/> I DO NOT ACCEPT ASSIGNMENT
SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction) 18	<input type="checkbox"/> MD 19 <input type="checkbox"/> DDS OR DMD 20
DATE SIGNED	DATE SIGNED

Physician's Office IH—Inpatient Hospital ECF—Extended Care Facility OL—Other Locations (Specify in 7C)
Independent Laboratory (give name and address in 7C) H—Patient's Home OH—Outpatient Hospital NH—Nursing Home

Physicians accepting an assignment of benefits under Medicare are required to complete Medical Form SSA 1490, which is reproduced on the adjacent page. Following is an explanation of how the form should be completed.

1. **NAME OF BENEFICIARY**—Record the patient's name as it appears on his red, white, and blue Health Insurance identification card.
2. **CLAIM NUMBER AND SEX**—Record the patient's claim number and sex as identified on his Health Insurance card. Please note: The claim number is NOT the same as the patient's social security number.
3. **CLAIMS INFORMATION**—This section is to be completed by the patient, whether you accept an assignment of benefits or bill the patient directly. However, if you accept an assignment, remind the patient to check the "YES" box.
4. **DATE OF EACH SERVICE**—Dates for intermittent services must be recorded individually. However, routine daily visits over a consecutive number of days may be grouped in one inclusive charge in this manner, "December 1-14." Indicate your charge per visit and the number of visits under Item 6. If a visit involves more than routine service, this visit must be listed separately in the date column and a separate explanation of the service must be provided in Item 6. Additionally, if your charge for an initial visit is higher than your charge for subsequent visits, that visit must be listed separately in the date column.
5. **PLACE OF SERVICE**—Use the letter symbols listed at the bottom of the form to indicate where the service was provided.
6. **SURGICAL OR MEDICAL PROCEDURES, SERVICES AND SUPPLIES**—Describe fully the services and/or supplies furnished on each date. If, under Item 4, you listed several visits as one inclusive charge, indicate the number of visits and your charge per visit here. If laboratory

service is a part of your charge, *do not* name the laboratory furnishing the service. If services were provided in a place other than the locations listed at the bottom of the page, specify the locations.

7. **NATURE OF ILLNESS OR INJURY**—Describe fully the diagnosis of the patient's ailment.
8. **CHARGES**—List your charges for services provided. If, under Item 4, you listed several visits as one inclusive charge, indicate your total charge for these visits here. If your charge for a service is more than you usually charge for that service, explain the extenuating circumstances which justify a larger fee.
9. **TOTAL CHARGES**—This is the sum of all charges listed under Item 8.
10. **AMOUNT PAID**—List any payments received from the patient. Remember, the patient is responsible for the first \$50 of any medical expense under Part B incurred during the year, and is also responsible for 20 percent of the "reasonable" charges incurred after he has paid the \$50 deductible.
11. **UNPAID BALANCE DUE**—The amount entered here is the difference between your total charge and the amount of payment which you have received from the patient.
- 12-13. **PHYSICIAN'S NAME, ADDRESS, TELEPHONE**—List your business office address and your business telephone number.
14. **CODE NUMBER**—It is not necessary for you to fill this space. This is an identifying number assigned to you by the Medicare carrier. The number is filled in by the carrier.
15. **ASSIGNMENT OF PATIENT'S BILL**—You must check the box labeled "I accept assignment." Your claim will be delayed if your patient checks the "Yes" box under Item 3 and you check the "I do not accept assignment" box under Item 15, or vice versa.
- 16-18. **SIGNATURE AND DATE**—You must sign the form, check the box indicating that you are an M.D., and record the date on which you signed the form.

Combination Form *(Continued from page 706)*

15. **TELEPHONE NUMBER**—List your business office telephone.
16. **CODE NUMBER**—It is not necessary for you to fill this space. The number is filled in by the carrier. This is an identifying number assigned to you by the Medicare carrier.
17. **ASSIGNMENT OF PATIENT'S BILL**—You

must check the box labeled "I accept assignment." Claims for public aid patients eligible for Medicare will be paid only if the physician accepts an assignment.

- 18-20. **SIGNATURE AND DATE**—You must sign the form, check the box indicating that you are an M.D., and record the date on which you signed the form.

REQUEST FOR PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
(Type or Print all Information)

Form Approved.
Budget Bureau No. 72-R730

Copy from your HEALTH INSURANCE CARD ➔	NAME OF BENEFICIARY (Patient) 1
	CLAIM NUMBER 2 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

Describe the illness or injury for which you received treatment. (You do not need to complete this item if your doctor completes it II below)

Is your illness or injury connected with your employment? ☐ YES ☐ NO 3. Are you attaching itemized bills? ☐ YES ☐ NO

ASSIGNMENT: Do you want payment for an unpaid bill made to the physician or supplier? ☐ YES ☐ NO

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other similar reproduction of this authorization to be used in place of the original.

REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services and supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

SIGNATURE (Patient or authorized representative)	DATE SIGNED
ADDRESS (Street address, City, State, ZIP Code)	TELEPHONE NUMBER

II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signature, Need Not Be Completed If Paid, Itemized Bills Are Submitted.

A. DATE OF SERVICE	B. PLACE OF SERVICE ¹	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (Diagnosis)	E. CHARGES	Leave Blank
5		6	7	\$ 8	
12 NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER (Number and street, City, State, ZIP Code)			TELEPHONE NUMBER 13	9. Total Charges \$ 9	
			CODE NO. 14	10. Amount Paid 10	
				11. Any Unpaid Balance Due \$ 11	

ASSIGNMENT OF PATIENT'S BILL (Reverse) 15 <input type="checkbox"/> I ACCEPT ASSIGNMENT <input type="checkbox"/> I DO NOT ACCEPT ASSIGNMENT	SIGNATURE OF PHYSICIAN OR SUPPLIER (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction) 16	<input type="checkbox"/> MD <input type="checkbox"/> DDS OR DMD 17	DATE SIGNED 18
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Physician's Office IH—Inpatient Hospital ECF—Extended Care Facility OL—Other Locations (Specify in 7C)
Independent Laboratory (give name and address in 7C) H—Patient's Home OH—Outpatient Hospital NH—Nursing Home

Physicians providing services to public aid patients must complete Form MS-132 (Revised 1-1-67), which is reproduced on the adjacent page. One copy of the form should be sent to the Illinois Department of Public Aid, 618 E. Washington St., Springfield 62706.

They must be submitted within 10 days after the end of the month in which the services were provided. Statements must be for one calendar month only. Information needed to complete MS-132 is included on a green identification card issued monthly to recipients by the Public Aid Department. Following is an explanation of how the form should be completed.

1. Enter here the month and year for which physician's services are being billed.

2-5. Information needed to complete these items will be found on the patient's green identification card. In all cases—except Aid to Dependent Children—the case name and the patient name will be the same. In ADC cases, the child's first name must be listed under Item 4. The child's name will be listed on the lower portion of the green identification card.

6. This space is for your bookkeeping convenience. The "account number" refers to the number your bookkeeping department has assigned to the patient.

7. Record the birth date of your patient.

8-9. Listed here are the six services most frequently provided to public aid patients. If the service for which you are billing is one of the six, merely check the appropriate square under Item 9 to indicate the date of the service. The Public Aid Department has asked that physicians list their diagnosis for any of the six services under Part II, Item 15.

10. List your total usual and customary charge for each type of service checked under Item 8.

11-12. List here the date and place for services other than the six listed under Item 8. Do not repeat charges listed under Part I. Use the initials at the bottom of the page to indicate the place of service. Note that you must specify under Item 14 where the service was provided if you use the initials "OL" under Item 12.

13. The code number for the procedure performed should be taken from *Current Procedural Terminology*, published by the AMA. Copies can be obtained by sending

a \$2 check or money order to the American Medical Association, Circulation and Records Department, 535 N. Dearborn St., Chicago 60610.

Injectables and dispensed drugs do not require a code number. List the code number for each laboratory procedure for which you are charging. For multiple surgical procedures, list the code number for the major surgical procedure unless a separate charge is necessary. Other procedures incidental to the major surgical procedure should be listed under Item 14 without the code number when no additional charge is being made.

14. In addition to listing the code number, it is necessary to describe fully the service provided or the supplies furnished. If you are billing for surgical assistance or for administering anesthesia, list the code number for the surgical procedure performed and indicate your exact service. Injectables and dispensed drugs should be reported here also. The reverse side of Form MS-132 includes an explanation of the payment policies of the department for these items.

15. List the diagnosis of the illness or injury requiring your service. Include a description of other conditions which may have complicated the treatment. If you use Part I, Items 8-9, list the diagnosis for these services here.

16. Record in this space your usual and customary charge for each service performed. For each procedure code, injectable, and dispensed drug listed, there must be a charge or "No Charge" notation inserted in this space.

17. List your total Part I and Part II charges for the month here.

18. Any payments which you have received from the patient, from whatever source, must be listed in this square.

19. The net charge is the difference between your total charges and any payments received from the patient.

20. List your name and business address.

21. Your AMA Medical Education number is recorded here. The number was provided earlier by ISMS but if it has been misplaced, contact the ISMS headquarters office. In a group practice, the medical education number of the physician providing the service must be listed.

22. Your signature here is your certification that the services were personally rendered, or rendered under your supervision.

23. Check the "M.D." square.

24. Record the date on which the form was signed.

PHYSICIAN'S STATEMENT OF SERVICES RENDERED

Services for **1** Month Year

(Type or Print all Information)

(Type or Print all Information)

Name: 2 _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Last 3 First </div>	← COPY FROM GREEN CASE I.D. CARD →	PATIENT'S FIRST NAME 4 _____ Case Identification Number 5 _____	Office Account No. 6 _____ Birthdate 7 _____
--	---	--	---

Leave Blank

Report of Routine Services

TYPE OF VISIT	Use Check Mark to Indicate Date of Visit																															Procedure Code	Leave Blank	Charges	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31				
Diagnostic																																	9004		
Nur. Home-Day																																	9001		
Nur. Home-Night																																	9021		
Initial Work-up																																	9073		
Subsequent																																	9016		
																																	9023		

II Report of Other Services (See Reverse Side)

Place of Service ¹	Procedure Code	Fully Describe Surgical or Medical Procedures and Other Services or Supplies Furnished For Each Date Given	Nature of Illness or Injury Requiring Services or Supplies (<i>Diagnosis</i>)	Charges
12	13	14	15	16

<p>Name and Address of Physician (Number and Street, City,, State, Zip Code) - Print, Type or Stamp</p> <p style="text-align: center;">20</p>	<p>Physician's AMA Medical Education Number (Print, Type or Stamp)</p> <p style="text-align: center;">21</p>	<table border="1"> <tr> <td>TOTAL CHARGE</td> <td>\$ 17</td> </tr> <tr> <td>CREDIT</td> <td>18</td> </tr> <tr> <td>NET CHARGE</td> <td>\$ 19</td> </tr> </table>	TOTAL CHARGE	\$ 17	CREDIT	18	NET CHARGE	\$ 19
TOTAL CHARGE	\$ 17							
CREDIT	18							
NET CHARGE	\$ 19							

hereby certify that I have rendered the services and provided the items set forth, that payment therefor has not been received, that the charge approved by the Department of Public Aid for each item will constitute the full and complete charge therefor, that I have not and will not accept additional payment for any of the items from any person or persons. I further certify that in compliance with Title VI of the Civil Rights Act of 1964 I have not discriminated on the grounds of race, color, or national origin in the provision of service.

Signature of Physician (A physician's signature certifies that physician's services personally rendered by him or under his personal direction.)

Check One:

☐ MD ☒ 23 ☐ DDS
or
DMD

Date Signed _____

24

CASE SIGN IN INK and send to the Illinois Department of Public Aid, 618 East Washington Street, Springfield, Illinois 62706

SPRINGFIELD OFFICE USE ONLY - Do Not Write in This Box

al Approval – If Required for Procedure Code(s): _____

Approved () Not Approved By: _____ Date: _____

10—Doctor's Office **IH**—Inpatient Hospital **ECF**—Extended Care Facility **H**—Patient's Home
OH—Outpatient Hospital **NH**—Nursing Home **OL**—Other locations (*Specify Under Procedures*)

DAYS OF OUR YEARS

By LOUIS D. BOSHERS, M.D./CHICAGO

Late one night some three years ago, I received a telephone call from a prominent member of the faculty of the University of Illinois College of Medicine asking if I could meet with him concerning a matter of importance in which I could play a leading role. Some days later I did meet with my caller who asked me if I would be interested in becoming Director of the Consultation Clinic for Epilepsy at the University of Illinois College of Medicine. Dr. Frederic W. Stamps, the former director, had died over a year ago leaving behind a legacy of exemplary experiences while working with this challenging large population of patients who had convulsive disorders. I was also told that both the head of the department of neurology and neurological surgery as well as the Director of the Division of Electroencephalography at the university had selected me as a likely candidate for the position, and as I left the conference I was given this message:

"Take it home, Lou; play it on your own piano and see how it comes out." So home I went to my piano and did some intense thinking, for I knew the decision was not going to be an easy one. I had been associated with Northwestern University since 1928 in a teaching capacity, for even as a student, I had been invited to become a member of the faculty in the College of Liberal Arts. Also, during my two internships, and I had two, one at the Michael Reese Hospital and Medical Center and the other at the Cook County Hospital, I taught the Cook County Quiz Course at the Northwestern Medical School at night, and some few years later became a member of the department of nervous and mental diseases. Accordingly, I continued to play the tune on my piano, at the time reasoning that I was accepting a challenge, a new look, and perhaps would have some new excitements which I had

not experienced heretofore. And so, I accepted the offer. It was very difficult to write, and even more difficult to present my resignation, and, as expected, I was asked to reconsider my action but I stood pat on my decision.

500 New Patients a Year

I soon came upon truly a confused scene in the consultation clinic, where I was to "soak" a little, and learn about it and then have the clinic learn about me. I found that the population numbered over 15,000 patients; 5,000 who were active at any and all times, some 5,200 patients who were in liaison with other clinics in the medical school, and some 5,000 others in reserve in the files who were potentially able to have recurrences of seizures at any time. New patients, I learned, numbered some 500 a year.

My staff was fairly large, being composed of staff clinicians, secretaries, electroencephalographic technicians and students, and a part-time voluntary social service worker attached to neurology and who was of invaluable help to me at all times. Other adjunctive services were offered to me almost immediately from the departments of psychiatry, medicine, surgery and from many other major areas in the university which seemed quite happy to welcome me to the university.

I expected, and I was not disillusioned, to find myself in a chaotic situation. The work was not easy and I could never count the hours that I spent initially at the university, usually working up to 11 or 12 every night after my office hours, and rather regularly over weekends. As a matter of fact, it is some three years later and this same situation holds to some degree. I use my university pass many nights and am in my office almost every day of the week to include, when necessary, weekends in order to keep up with the large bulk of clinic work and correspondence.

Staff is Intact, Constant

There are the usual administrative prob-

Presidential address, Chicago Neurological Society, May 10, 1966.

lems, personality problems, as there are in any staff amongst attending physicians, secretaries, technicians, but I can state that the staff has been intact; in fact, it has been constant. There is always a countless and endless mass of correspondence from physicians, schools, agencies, hospitals, etc., in the city, from every area in the state, from many places in this country, and from many foreign countries. All of these letters must pass over my desk and they must be answered. It is not uncommon after a radio or television appearance, and I am expected to make many of these, that I may receive up to 28,000 letters in a response but fortunately, companies such as Ayerst, catering to the discipline, have been quite understanding and of great help in helping to answer this massive correspondence. There are disappointments, frustrations, rejections, and since these are all expected, I am not dismayed. Many hours are spent in writing grants, some are approved and funded, and others which are approved and not funded, and still others are rejected. There are the usual trips to Washington to visit in with those who control these grants. There are demands for talks to be given in this country and abroad, and at present, I have three invitations to speak in foreign countries. These and others, are the usual requests from the Public Information Office which must be honored. This large price has been a small price, indeed, as far as I am concerned, because without a doubt these last few years have been three of the most pleasant in my medical life. I wanted, needed, and requested excitement, and believe me, this is what I received.

Lifetime Interest in Epilepsy

Tonight as I reflect on these thoughts, they move back over those many years in which I have had an interest in epilepsy. As I look backwards, I find that a lifetime in medicine has been spent with interest in this symptom, all-in-all some 35 years. As I think of this third of a century which has passed, I can not help but correlate my thoughts to a recent recording which I heard a few months ago and which I loved immediately. I believe that this song will become a classic and rate with other standards such as "Stardust", "Blue Skies", "Some Of These Days", "Mood Indigo", "I'll See You In My Dreams", "Russian

Lullaby", etc. This song was introduced on a television program some months ago by a young old man named Frank Sinatra, and the album is entitled "September Of My Years". In it Sinatra sings of his September reflections. He sings of the old penny days, of the rose lipped girls, and candy-apple times, of cold and chilly winds, and of a fair lass who has perfumed hair. These are Sinatra's April thoughts. He sings with perspective, this vital man, this archetype of the good life, this idolized star. Now he pauses and looks back. He remembers and graces the memory with a poet vision. For here is a man who has lived two lives and he can now sing of December of his life, of the bruising days, of the rose lips, and the bourbon times, of the cold and chilly winds, and of forgotten ladies who ride in limousines. September can only be an attitude of age of a wishful reality. As for Sinatra, it is a time of love, a time to sing, a thousand days hath September for this man. Rat Pack leader or rumored Cosa Nostra chieftain, Sinatra sings well.

"It Was a Very Good Year"

Since tonight is truly my night, I possess, therefore, the poetic license to have had you listen to this record called "It Was a Very Good Year." Remember last year Sid Schulman, the out-going President, had you join him in the pleasures of monkey watching? Next year, in all likelihood, Hal Koenig will toast his winged friends. The record forms the basis of my reflections tonight.

When I was 17 it was a very good year. When I was 17 was it a good year for epilepsy? For this was now in the late 1920's and there was still not too much available for the management of this symptom.

Some 70 years before this, a Sir Charles Locock, while at a meeting of the Royal College and Chirurgical Society of London was listening to a paper being given by a Dr. Edward Henry Sieveking entitled "An Analysis of 52 Cases of Epilepsy Observed By The Author". There were three discussants with the last being the chairman, Sir Charles himself, who made these three specific points: First, that epilepsy could be caused by crowded teeth; second, that the practice of onanism might account for the grave increase of epilepsy in recent years; and third, that there was some form

of hysterical epilepsy connected with the menstrual period. It seems that Sir Charles had read an account of a German gentleman who had become impotent by simply taking 30 grains of potassium bromide daily for a period of two weeks. The speaker went on to state that as a result he had used bromides at first on non-epileptic hysterical females and later on hysterical epileptic females who had attacks which occurred monthly and he found that in both, there was complete success. His series, Sir Charles noted, was increasing and out of 14 or 15 cases being treated with bromides, only one was unsuccessful. That evening, a man made some off the cuff remarks about the treatment of epilepsy at a routine medical meeting in the city of London but apparently never followed up by writing anything on the subject. And so, Sir Charles gave us bromides.

Phenobarbital in Clinical Use

And when I was 17 there was another drug in clinical use called phenobarbital introduced by a German scientist in 1912. Although not Jewish, under Nazism he was interned in a concentration camp from which he managed to escape to reach America where he continued to practice neurology and conduct research until his death in Boston in 1948. Dr. Alfred Hauptman was his name and he wrote some 61 papers but the important one was written in 1912 entitled "Die Behandlung Bei Epilepsie mit Luminal". The first report in America on Phenobarbital or Luminal, as it was called then, was given by Dr. Julius Grinker in 1920. So there were now two drugs when I was 17 and it was a very good year here in Chicago for those who prescribed these drugs and for those who required them.

When I was 21 it was a very good year for this was the year that I first began to work with patients who had seizures. I was only a medical student, and a lowly sophomore at that. Dr. Louis J. Pollock was chairman of the department of nervous and mental diseases, as it was called at that time, and the entire department was bromide oriented, and I do mean bromide oriented. Many patients, private and clinic, came to the medical school regularly and upon these, I drew blood for blood bromide determinations, for this was the only method that we had at that time to gauge whether a patient had bromidism as

the cause of his clinical symptoms of intoxication. I remember the procedure well as I remember some of the patients who came. There was a well known bearded travelog lecturer who filled Orchestra Hall regularly. He spoke beautifully and showed his equally beautiful 35 mm projections of the many countries that he visited. And there was a pretty 21 year old society girl on whom I just never was able to hit the vein the first time, and I often wondered who was the more nervous, she or I, but after all, I was just a sophomore. I remember the day that she came crying bitterly to tell me that the night before, she had had a massive seizure in the presence of her fiance who knew nothing of her affliction and who left her abruptly telling her that he would never return. The marriage had been hailed in every newspaper in the city as the wedding of the year. And then there was a man who later became king of a radio empire and even later of a television domain who also had blood bromide determinations made by me regularly. Later, he was to stand off with a machine gun, invaders, as he imagined, of his yacht anchored at the foot of Monroe St. in the yacht basin. Even as a sophomore, I wondered if his seizures in his psychomotor state were not firing the paranoid thoughts that he had even directed toward me, and I was only a sophomore. Yes, this was a very good year and I enjoyed it because somehow or other I knew then that epilepsy was a symptom in which I would one day become more than vitally interested. I hoped that there would be something better than bromides, even something more efficacious than phenobarbital, newer drugs, better drugs to control the convulsive attacks.

Dispensed Bromides by the Quart

When I was 25 it was a very good year. I was now a senior medical student in the clinics—confident, composed, cocky, and I always looked forward to my afternoons in the neurology clinic where I dispensed bromides by the quart. Many of us sitting in the audience tonight must remember patients they saw with somnolence, acne, thickness of speech, ataxia of gait, and even psychosis. I really don't know how many cases of arsenic poisoning I personally caused with the Fowler Solution that was added to each bottle but I can assure you I did my share—and I was only a senior.

How could I ever forget the lady who had nocturnal seizures and to whom I gave bromides, plenty of bromides to be taken at 9:30 each night. I asked her to come back to the clinic in a week. And somehow or other she did stagger back into the clinic a week later to tell me that she no longer had seizures and I was so delighted with my clinical acumen. But then she told me that she had encountered so much difficulty in remaining awake during the night. Then, and only then, did I learn that she was a janitoress who worked during the night, at the same time fighting my bromides. I have never failed as a result, to ask questions about occupation, day or night.

Clinic Patient Is Inventor

And then there was a little man who was the inventor of talking pictures who was always penniless when he came to the clinic. And at that time he told us he was suing the William Fox Co. who had literally "stolen" his invention. This in turn was "stolen" from William Fox by RCA and this little man, the inventor, from time to time would have to go from one city to another to be the witness for one or the other against the other and this little man only had his expenses paid for his appearances in the court. And even in the mid 1930's he told me that he and his heirs up until that point should have realized \$600,000,000 from his invention. Somehow or other, this potentially rich little man never had 30 cents for his six ounces of bromides, but my lunch money was always there for him so that he could continue to dream of what he might have had. And he worked, when he was able, in a laboratory which Dr. Pollock had arranged for him. Oh yes, he invented many other things. The old lock for the steering wheel of the Ford was his. He was working on "soft" x-rays to visualize blood vessels in the brain and in the stomach when he died penniless, still dreaming and still on my bromides.

The next few years were good years and I interned at two hospitals, first at the Michael Reese Hospital and Medical Center and later at County. In both I encountered many patients with bromide intoxication so, again routinely, I continued to make blood bromide determinations. Usually, I found that most of the patients had histories of being either in a private or clinic care of the staff at the North-

western University Medical School. Soon I was reading regularly the literature about deterioration of patients with bromidism. Amongst the writings were experiences with patients intramural and extramural with intellectual changes in monumental papers by the late Dr. Harry Paskind and our Meyer Brown. I read about carbohydrate metabolism in the work of Dr. Louis J. Pollock and brother Ben. I read the writings of Irving Sherman and Alex Arieff who were just beginning to start reporting statistics of the Seizure Clinic at Northwestern University. Alex is still doing this and recently reported just 35 years of experiences in the same clinic. I followed the work of Roland Mackay then at St. Luke's, Loren Avery at Presbyterian, Dick Richter and Doug Buchanan at Billings, Ben Lichtenstein at Sinai, the late Ted Stone at Wesley, Joe Luhan and the late Leo Kaplan at Mercy and Loretto Hospitals.

Drugs to Prevent Convulsions

Some few years later in Boston, Dr. Tracy Jackson Putnam had also been doing some thinking about epilepsy and he had a hunch that perhaps systematic screening of drugs might uncover even better anticonvulsants. He reasoned that the sedative effect be forgotten for awhile and instead to try to attempt to do things with drugs with chemical structures made to order such as the phenyl ring and possibly even those with two rings. Dr. Tracy Putnam thought that he would enlist the help of animals in his laboratory to work out his hunch. So this was done eventually and Parke-Davis and Co. supplied a great numbers of chemicals to a South Carolinian named H. Houston Merritt who, with his technician, Dorothy Miller, later to become Mrs. Bob Schwab, undertook this Ehrlich type of task, laborious and unpleasant, of testing the ability of various drugs to prevent convulsions which these experimenters were electrically inducing in cats. And of these many chemicals supplied by Parke-Davis and Co., one called Sodium Diphenylhydantoin seemed to combine effectiveness with absence of side reactions. So Tracy Putnam's hunch had paid off. The rest is history, for in June, 1937, Putnam and Merritt reported their first results with animals to the American Neurological Association and in humans the next year at the American Medical

Association Annual Meeting. So this was a very good year. And some of this medication was soon in Chicago obtained and used by many of us. And I can remember receiving a call from a dentist in northern Wisconsin about a patient who I was now managing with Dilantin and who for the first time was seizure free. This dentist threatened me with police action for causing such devastation with a new, dangerous, and poisonous drug and he promised me that he would bring me before every ethical board of every medical society to show how inhuman I was in ruining the gums of this patient.

Rush of Drugs Comes

And Dilantin was also given to Ted K., a patient intractable with seizures who worked at printing *Popular Mechanics*, not on the press but inside the press. Certainly I made him change his work and he did, and Ted began to drive trailers through the night to destinations some 300 miles away. A later job was even less comforting to me—this time on a Mississippi River boat on the run from St. Louis to New Orleans. But being a splendid swimmer, he did not ride in the boat, he swam most of the way. And on a wintery Sunday afternoon in a public park ice skating rink, I found him competing in the short sprint races, later playing ice hockey. I still manage him and recently he informed me that he wishes to become a forest ranger. But this was a very good year and I continued to use this medication plus the others and watched others around me doing the same thing.

Soon the rush was on and the drugs came, one after the other, with each company hoping that its drug would be ideal with the usual three demands that they be: (1) anticonvulsant, (2) non-sedative, and (3) non-toxic, but this could not possibly happen so easily. So, into Chicago in 1944 arrived Tridione, synthesized by Spielman as a possible analgesic but proven anticonvulsant for small animals by Everett and Richards of the Abbott Laboratories. There was quick and complete acceptance of Tridione here in the city as it was world-wide, for this drug had no competition. After all, Dilantin had phenobarbital, and phenobarbital competed with bromide. Many patients who resigned themselves to the petit mal and petit mal

variant type of seizures abruptly found themselves free. But Roland Mackay warned that Tridione even in doses that were not unusually large might result in acute aplastic anemia, agranulocytosis, thrombocytopenia, and death, even some few days after the start of this medication. In 1946, Tridione was reported by Mike Perlstein and Mort Andelman as being ideal as a drug for seizure patients even with grand mal and/or psychomotor epilepsy.

Gibbs' Influence Immediate

Two years earlier, the two Gibbsses, Fred and Erna, came upon the Chicago scene and the impact was almost immediate as was their influence in the field of epilepsy which has remained constant and even continuing not only in this city but in every city of the civilized world. But it is not only their monumental work in electroencephalography but also in their development of many drugs still in active use. Both Erna and Fred Gibbs did the electroencephalographic work initially with Dilantin with the team of Putnam, Merritt, and Miller. Erna and Fred introduced monopolar recordings to students from every corner of the world through research and teaching. At the same time they amassed an appalling number of records that have been documented in their three-volume atlas, truly the "Bible" of electroencephalography. And the same pair introduced the 14 and 6 concept, the psychomotor equivalent (memories of Friday, Nov. 22, 1963 plus an aftermath two days later), hypsarhythmia, "mitten," and other aspects in the field in which they stand alone. In 1948, together with Everett and Richards, they reported on Phenurone. This is another drug that seemed to come upon Chicago with truly a "bang" and I can recall one of the first patients on the drug who had quite a violent response to it. She was found that same night wandering in Lincoln Park in her silk nightie and the temperature was only 8 degrees below zero. Soon other complications were reported as Phenurone came into wider usage. In 1946, Kozol gave the first enthusiastic report on Mesantoin and it was soon in popular usage here in Chicago and everywhere else. Quickly we learned some

(Continued on page 724)



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CAUTION: Should not be given concurrently with monoamine oxidase inhibitors. It should be used with caution in patients having a sensitivity to sympathomimetic compounds or barbiturates and in cases of coronary or cardiovascular disease or severe hypertension. Excessive use of amphetamines by unstable individuals has been reported to result in a psychological dependence. In such instances, withdrawal of the medication is necessary. All medication should be used with caution in pregnant patients especially in the first trimester.

SIDE EFFECTS: Insomnia, excitability, nervousness may occur if dosage is excessive. These occur infrequently and are mild with the recommended dosage.

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EDECIN Diuretic—Other R

Manufacturer: Merck Sharp & Dohme

Nonproprietary Name: Ethacrynic Acid

Indications: Congestive heart failure, acute pulmonary edema, renal edema, hepatic cirrhosis with ascites, edema due to other causes.

Contraindications: In patients with anuria, azotemia and/or oliguria. If severe, watery diarrhea occurs, Edecin should be discontinued. Not to be administered to infants.

Dosage: 50-200 mg. daily, in divided doses, after meals.

Supplied: Tablets—25 and 50 mg.; bottles of 100.

LIBRITABS Ataraxic R

Manufacturer: Roche Laboratories

Nonproprietary Name: Chlordiazepoxide

Indications: Mild and moderate anxiety and tension, alone or associated with organic disorders or psychoneurotic reactions; preoperative apprehension.

Contraindications: Known hypersensitivity to the drug.

Dosage: Adults—5 to 25 mg., 2-4 times daily. Children over 6 years, 5 to 10 mg., 2-4 times daily.

Supplied: Tablets—5, 10 and 25 mg.; bottles of 100.

LYOVAC SODIUM EDECIN Diuretic—Other R

Manufacturer: Merck Sharp & Dohme

Nonproprietary Name: Sodium Ethacrylate

Indications: Congestive heart failure, acute pulmonary edema, renal edema, hepatic cirrhosis with ascites, edema due to other causes. For use when oral intake is impractical, or in urgent conditions.

Contraindications: In patients with anuria, azotemia and/or oliguria. Not for pediatric use. Should not be administered with whole blood or its derivatives, i.m. or subcutaneously.

Dosage: 0.5 to 1 mg./kg. body weight.

Supplied: Vials—equivalent to 50 mg. ethacrynic acid, to be reconstituted.

MACRODEX Hospital Solution R

Manufacturer: Pharmacia Laboratories

Nonproprietary Name: Dextran 70

Indications: Plasma volume expander

Dosage: 500 to 1000 cc., i.v.

Supplied: Bottles of 500 cc.

(Continued on page 744)

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Therapeutic Effects: Stiffness and pain may diminish within 2 days, and full mobility may be restored within a week. These effects are obtained with oxyphenbutazone alone or combined with physiotherapy or local hormonal injections. The drug is usually well tolerated and does not affect pituitary-adrenal function or immune response.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

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Product Information

Contraindications: Use in pregnancy:

When administered to rats at doses substantially above the human therapeutic range, hydroxyzine induced fetal abnormalities. Until human clinical data are available adequate to establish safety in early pregnancy, hydroxyzine is contraindicated in early pregnancy. The drug is contraindicated for patients who have shown previous hypersensitivity to it.

Precautions: Hydroxyzine HCl may potentiate narcotics, barbiturates, meperidine and other CNS depressants. In conjunctive use, dosage of these drugs should be reduced by as much as 50 per cent. Atropine and other belladonna alkaloids are not affected by hydroxyzine. Because drowsiness may occur, patients given hydroxyzine should be cautioned against driving a car or operating dangerous machinery.

Adverse reactions: No serious side effects resulting from the oral administration of hydroxyzine have been reported and confirmed to date. Therapeutic doses seldom produce impairment of mental alertness. The transitory drowsiness that may occur usually disappears spontaneously in a few days of continued therapy or can be corrected by dosage reduction. Dryness of the mouth may be encountered at higher doses.

The absence of toxic effects on the liver and bone marrow has been demonstrated by extensive clinical use at recommended doses for more than four years of uninterrupted therapy and by experimental studies in which excessively high doses were given. Involuntary motor activity, including rare instances of tremor and convulsions, has been reported, usually with considerably higher than recommended doses.

Dosage: Ranges from 25 mg. t.i.d. to 100 mg. q.i.d.

References: 1. Fishbein, M.: J. Am. Geriatrics Soc. 10:911 (Nov.) 1962. 2. Dole, P. W.: New England J. Med. 265:185 (July 27) 1961. 3. Settel, E.: Am. Pract. 8:1584 (Oct.) 1957.



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Crippled Children's Clinics

Twenty-two clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The division will count 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be six special clinics for children with cardiac conditions and rheumatic fever, and one for children with cerebral palsy. Clinicians are selected from among private physicians who are certified board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 1, Springfield General—St. John's Hospital

June 1, Lake County Cardiac—Victory Memorial Hospital

June 7, Alton Rheumatic Fever & Cardiac—Alton Memorial Hospital

June 7, Carmi—Carmi Township Hospital

June 7, Hinsdale—Hinsdale Sanitarium

June 8, Macomb—St. Francis Hospital

June 8, Effingham General—St. Anthony Memorial Hospital

June 9, Chicago Heights Cardiac—St. James Hospital

June 9, Evanston—St. Francis Hospital

June 13, Belleville—St. Elizabeth's Hospital

June 13, Peoria General—Children's Hospital

June 14, Champaign-Urbana—McKinley Hospital

June 15, Bloomington—St. Joseph's Hospital

June 15, Rockford—St. Anthony's Hospital

June 15, Elmhurst Cardiac—Memorial Hospital of DuPage County

June 21, Chicago Heights General—St. James Hospital

June 23, Chicago Heights Cardiac—St. James Hospital

June 27, East St. Louis—St. Mary's Hospital

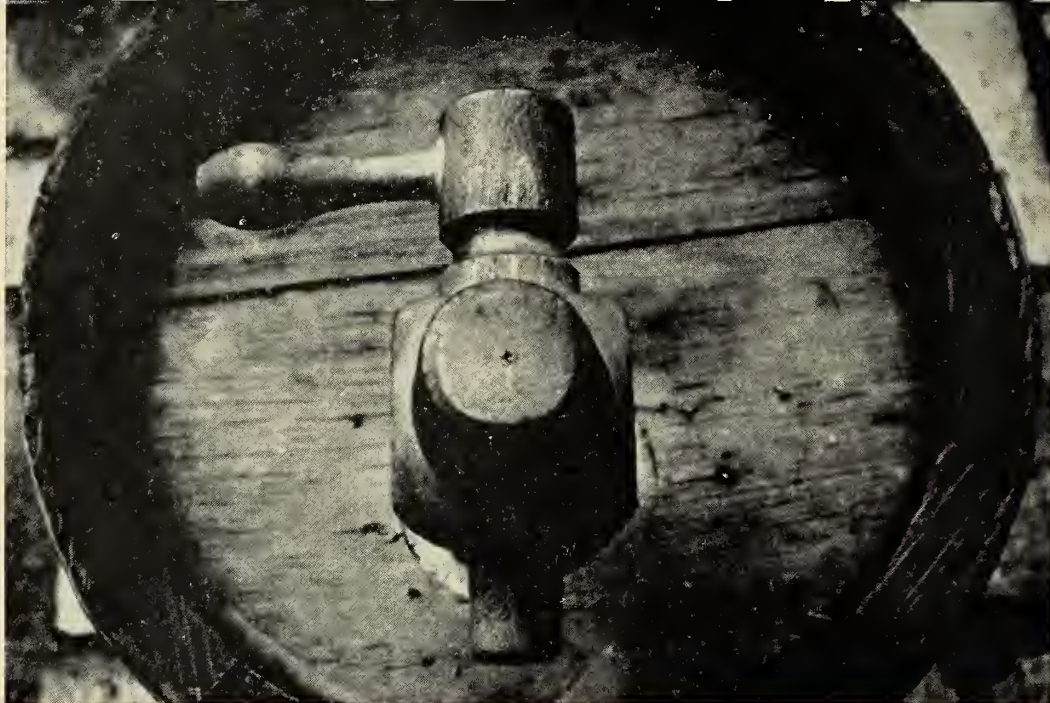
June 27, Peoria General—Children's Hospital

June 28, Springfield Cerebral Palsy (P.M.)—Diocesan Center, St. Paul's Cathedral 815 So. 2nd

June 28, Aurora—Copley Memorial Hospital

June 29, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

DIURESIS



MERCUHYDRIN[®] (meralluride injection)



Twenty years ago the publication of "A System for the Routine Treatment of the Failing Heart"¹ established a schedule of diuretic therapy as a primary factor in the treatment of acute congestive failure. With emphasis upon daily injections of Mercuhydrin (meralluride injection) until dry weight was obtained, Gold, et al. achieved a 40% increase in improvement, in 1/3 the time, over other methods then current. Today, most medical texts continue to recommend parenteral mercurials in acute congestive failure when prompt diuresis is indicated.

Recently Modell² has stated: "The mercurial diuretics are the injectable diuretics of choice since they are the most potent as well as the most dependable. Their toxicity is not an important consideration either by comparison with other potent diuretics or in relation to the seriousness of the conditions in which they provide such excellent relief."

IN BRIEF

Mercuhydrin is indicated in edema of cardiac or hepatic origin and in the nephrotic syndrome; it is contraindicated in acute nephritis and in anuric or oliguric states. *The usual adult dose is one to two cc. daily or every other day until "dry weight" is obtained.* Sensitivity is rare but small initial doses are advised to minimize potential reactions; vertigo, fever, and rash have occurred. Overdosage may produce electrolyte depletion, muscle cramps, and G.I. reactions. Supplied: 1 cc. and 2 cc. ampuls in boxes of 12, 25 and 100; 10 cc. rubber capped, multiple-dose vials (intramuscular or subcutaneous use only) in boxes of 6 and 100.

1. Gold, Harry, et al.: *A System for the Routine Treatment of the Failing Heart*, The American Journal of Medicine, Vol. III, No. 6:665-692 (Dec.) 1956.

2. Modell, Walter: *Drugs of Choice* 1966-1967, p. 97, 1966.

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Days of Our Years

(Continued from page 716)

of the dangerous side reactions and respected these. A few years later in the Mandel Clinic, Irving Sherman and I saw a man with two well developed breasts who had been managed on Mesantoin. Ben Lichtenstein also knew him well and all of us agreed that this was a drug reaction and in all likelihood caused by Mesantoin. But the manufacturer said it could not be and only later did the same company admit to this and to other possible endocrine changes in patients on Mesantoin.

Seizure Management with Antibiotics

In 1948, here in our city, Paradione, a splendid drug, came into view through the efforts of Everett and Richards as did Phenurone as already described in the same year. Gemonil was introduced in 1950 and once again Mike Perlstein wrote on his experiences with this splendid drug. And F. Zimmerman introduced Miltown, and a year later came this splendid drug named Mysoline which has found such great and variegated use in the various types of seizures. But Mysoline had its difficulties inasmuch as dosages were never ascertained. And it was my good fortune to work with the chemists and the pharmacists at Ayerst in helping to develop the 50 mg test tablets. In the same year, Bergstrom brought forth Diamox which was used considerably in Chicago and at the same time the late Frederick W. Stamps, Erna Gibbs, and the late Ernst Haase, a gentleman of gentlemen, treated epileptic patients with Aureomycin and introduced new concepts of managing the seizure state with antibiotics. How could anyone ever forget gentle Ernst as he died in the arms of some of us one Tuesday night at a Chicago Neurological Society meeting?

In 1946 Peganone appeared as another Chicago contribution by Schwade, Richards, and Everett. And so, each drug came, with Chicago as a testing ground usually, because after all, were not most of these drugs born in Chicago or in the Chicago area? In 1949 both Gibbsses and Dr. Ira Rosenthal reported on the management of hypsarrhythmia with ACTH. Many years later they changed their thoughts on the management of this disorder. Oh yes, there is also Celontin, Desoxyn, Dexedrine, Elipten, Gemonil, Librium, Mebaral, Mep-

robamate, Milontin, Paraldehyde, and Zarontin. And there was M-144 and AC 601, Conadil, Ospolot and Transpoise. The day the paper written by two of my staff extolling the virtues of Transpoise appeared in the literature, the drug was withdrawn from the market by the FDA.

Surgical Therapy Introduced

Later Alex Arieff and Manuel Mier told us of Tegretol for the psychomotor state, but freely admitted that this drug seemed to do more good for facial pain. This has been proven over and over, not only in Chicago but elsewhere in the world. Dr. Evelyn Anderson, Fred Gibbs, and your speaker, introduced Mogadon to Chicago and informed the society of the value of parenteral Librium and Valium.

Everyone in our city always asked "what success drug therapy" and God knows. We don't know why some patients do not respond to the best efforts that we give. Accordingly, surgical therapy was introduced on the Chicago scene and especially at the University of Illinois College of Medicine through the efforts of Dr. Eric Oldberg, Percival Bailey, and Oscar Sugar. The admonitions by Penfield are in the closing paragraph of the book by Penfield and Jasper and in 1954 he said "Throughout the analysis of every case the clinician should be first and foremost a wise physician and an understanding friend of the patient. He should weigh for him the chances of success by surgery and balance this against the best that conservative treatment can promise. He must see the whole problem in the perspective of the patients only outlook upon life." And so, the indications and the contraindications of surgical management for intractable epilepsy were laid down properly and are followed judiciously in the major areas on the Chicago scene where there are many patients who require this type of direction. In the past year there has again been an impetus here in Chicago with new drugs appearing regularly. These are evaluated, some kept, some discarded, and some are still under focus. Regularly these drugs are brought to my laboratory where I evaluate them for Phase II or Phase III to see whether or not they are adequate for our needs and for the proper use in our patient group.

And so I say to myself over and over,
(Continued on page 754)

Mild mood depression, poor appetite, little interest in the present or future. Does this picture mean that she's giving in to functional fatigue?

When functional fatigue is part of her problem, Alertonic can help counteract accompanying apathy and inertia. It helps lift mood, stimulate appetite, and establish new interest in daily life.

Pleasant-tasting Alertonic combines pipradrol hydrochloride—a gentle cerebral stimulant—with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Especially in the aging patient, nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding, and encouragement. Between visits, however, your prescription for Alertonic can help keep your patient from giving in to functional fatigue.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Available only on prescription
Alertonic[®]

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%, pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B₁) (10 MDR*), 10 mg.; riboflavin (vitamin B₂) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B₆), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.

†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY

Division of Richardson-Merrell Inc.

Cincinnati, Ohio 45215



THE VIEW BOX

By LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Associate Professor of Radiology, Chicago Medical School*

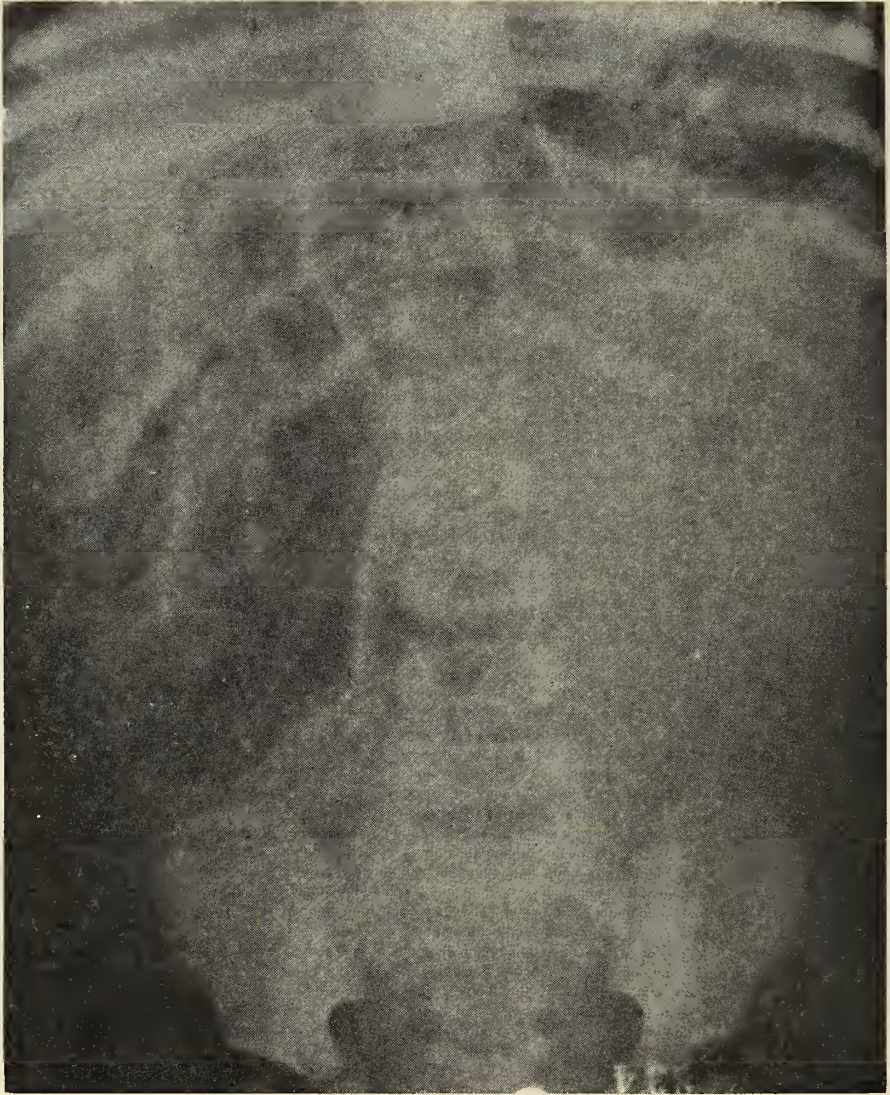


Fig. 1.

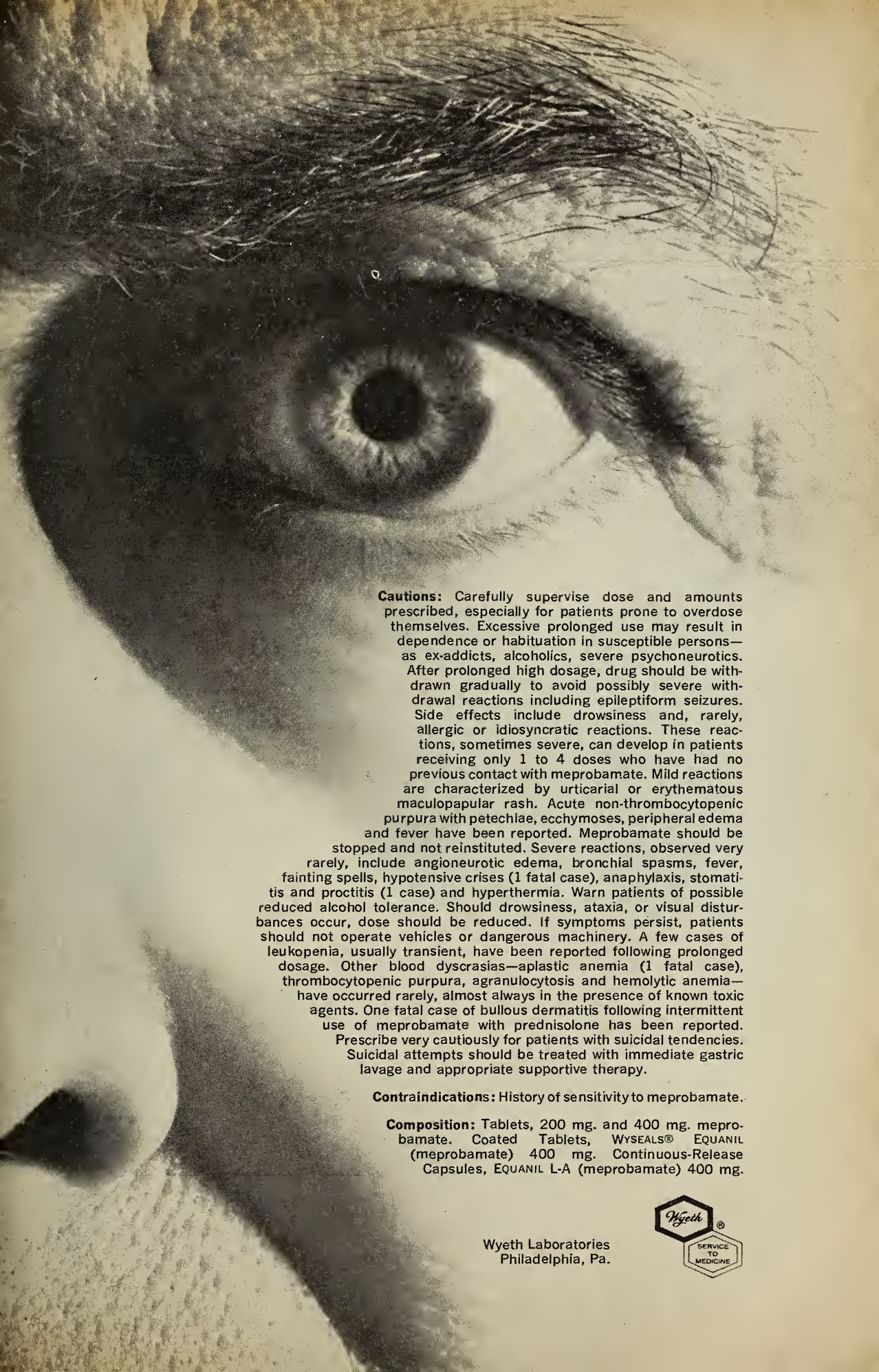
This 6-year-old W/M entered the hospital with colicky abdominal pain of six days duration. Vomiting had started 24 hours prior to admission and was bile stained.

Physical examination revealed a distended abdomen with increased peristaltic activity. There was no evidence of localized abdominal tenderness. The white blood count was 25,000 with segmented forms 83 percent, lymphocytes 15 percent, mononuclears two percent.

What's your diagnosis?

- (1) appendicitis.
- (2) ascaris ileus.
- (3) intussusception.

Answer on page 732



Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. Meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leukopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories
Philadelphia, Pa.



— THE VIEW BOX —

DIAGNOSIS AND DISCUSSION

(Continued from page 728)

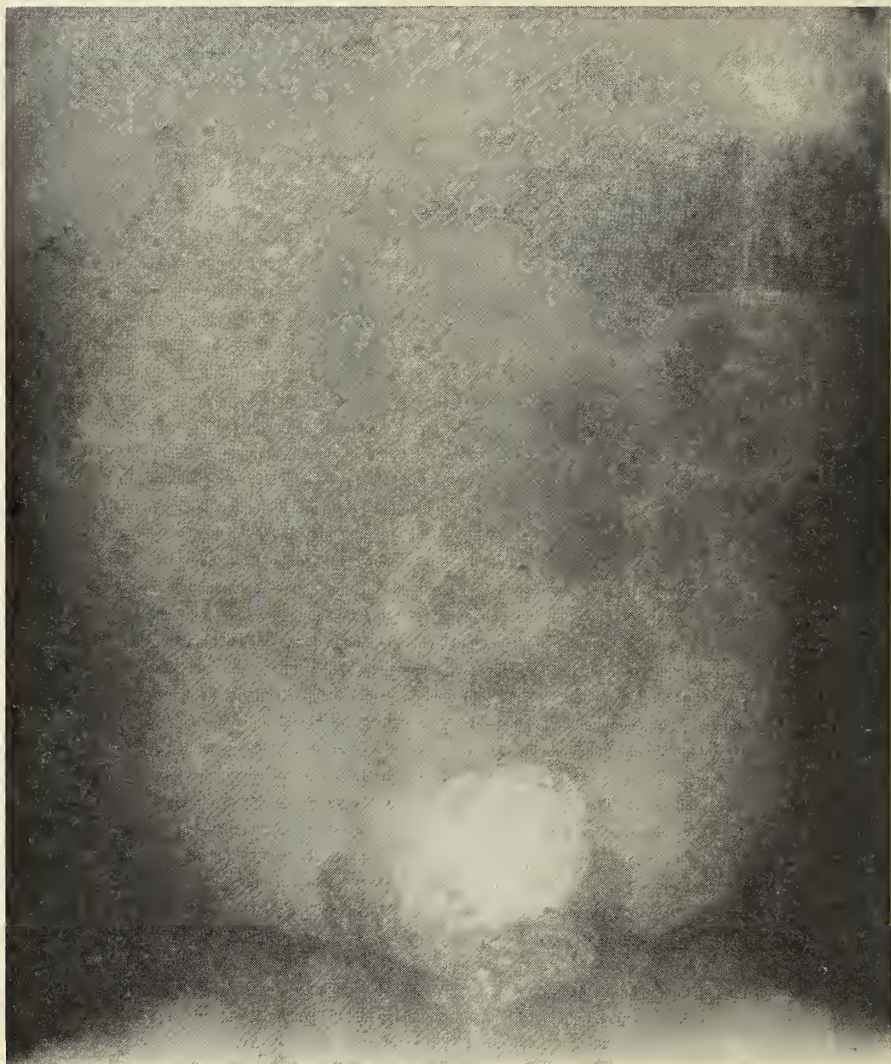


Fig. 2.

DIAGNOSIS: *Ascaris* ileus.

The recognition of *ascaris* adult forms on the scout film of the abdomen depends on the density of the worm contrasting with the air filled bowel. Their appearance can be likened to a tangle of thick cords (note the right mid abdomen).

Two stages in the life cycle of the worm may produce symptoms: first, the larval stage, when deposition and inflammation takes place in the alveoli; second, when the adult worms are lodged in the small bowel. If the mature worms migrate in sufficient numbers, an obstruction of the bowel may result which may require surgical relief. Eosinophilia may or may not be present. A barium enema was done which demonstrated the worms coated by barium in the large bowel. The patient was given a vermifuge and his symptoms were relieved.

References:

"*Ascaris* Ileus in Children" J. J. McCort, *Radiology* 1958, 70:528-531.

ILLINOIS MEDICAL ASSISTANTS ASSOCIATION REPORT



By RUTH G. CHRISTENSEN

"WANTED: TRAINED MEDICAL ASSISTANT. Opportunities unlimited. CMA* preferred. Will consider others."

*CMA—Certified Medical Assistant

Such an ad might appear in the newspaper sometime in the future, but until recently the sad truth is there were few places someone wishing to enter the field of medical assisting could be trained. She usually had to be trained on the job.

Medical assistants have long felt that this was not a satisfactory method of training for the complex job that medical assisting has become today. They themselves, as well as many of their doctor-employers, have spent much time in talking to faculty members at junior colleges, encouraging them to incorporate a medical assisting program in their curriculum built around the study outline for the Certification Examination for medical assistants. Even where this has been accomplished, the quality of the course has tended to vary from school to school. Commercial schools of medical assisting have been, in general, entirely inadequate as well as unreasonably expensive for the student. Therefore, the American Association of Medical Assistants has wanted to institute a program of approval of schools. Because of the expense involved this has not been possible until last October, when Lederle Laboratories made a \$5,000 contribution to the school approval program.

Mr. Paul Stessel, Director of Public Relations for Lederle said at the time he presented the check:

"In keeping with its long-standing interest in providing functional services to the private medical practitioner, Lederle Laboratories has agreed to support the implementation of the school approval program. In this regard, the facilities of Lederle's Physician's Community Service have been

made available to AAMA. The PCS is dedicated to the maintenance and development of community health leadership by community physicians."

The American Association of Medical Assistants has been one of the few paramedical groups that has not had an approval program. As a result, students have not been able to receive help in selecting a school from lists of approved schools such as are available from the AMA on schools of nursing, x-ray technology, and medical technology to mention only a few.

Establishing an approval program is a tremendous and an important long-range job. A committee of medical assistants, (the majority of whom are CMA's) educators, doctors and a representative of the AMA were appointed to lay the groundwork. The committee drew up guidelines for the program and began to study and evaluate the medical assisting courses currently offered by accredited junior colleges in the United States. The evaluation, which it is hoped will be completed in two years, will finally request the AMA Council on Medical Education to recommend to their House of Delegates that a school approval program for medical assisting training be established under the sponsorship of the council, in cooperation with AAMA.

The effectiveness of this program will become apparent for the first time at least three years after the students of these junior college courses graduate and their knowledge is tested by the certification examination. Only then can it be determined if the courses are adequately planned and taught.

This project is a major undertaking, but the increasing interest in this area shown by state and federal governments and other outside groups makes it mandatory for AAMA to take the lead and set standards for the profession.

New Pharmaceutical Specialties

(Continued from page 718)

RHEOMACRODEX Hospital Solution Rx

Manufacturer: Pharmacia Laboratories

Nonproprietary Name: Dextran 40

Indications: As a priming fluid, alone or as an additive, in pump oxygenators during extracorporeal circulation.

Contraindications: Marked thrombocytopenia, hypofibrinogenemia, and renal diseases with severe oliguria or anuria.

Dosage: 10 to 20 cc./kg. body weight, to be added to the perfusion circuit.

Supplied: Bottles of 500 cc.

Rheomacrodex

Rheomacrodex 10% in Normal Saline

Rheomacrodex 10% in 5% Dextrose in Water

ETHAMIDE Diuretic—Other Rx

Manufacturer: Allergan Pharmaceuticals

Nonproprietary Name: Ethoxzolamide

Indications: Chronic simple glaucoma, preoperative acute and chronic congestive glaucoma, acute secondary glaucoma, and preoperative control of intraocular pressure.

Contraindications: In patients with idiopathic renal hyperchloremic acidosis, renal failure, a known depletion of sodium and/or potassium serum levels, and Addison's disease.

Dosage: One tablet 2 to 4 times daily.

Supplied: Tablets—125 mg.; bottles of 100.

COMBINATION PRODUCTS

NATABEC—F.A. Vitamin/Mineral Comb.—Prenatal o-t-c

Manufacturer: Parke, Davis & Co.

Composition: Calcium carbonate

Ferrous sulfate

Folic acid 0.1 mg.

Nicotinamide

Vitamins A, B1, B2, B6, B12, C, and D.

Indications: Dietary supplement during pregnancy and lactation.

Dosage: Not stated.

Supplied: Bottles of 100 and 1000 Kapseals.

ORTHO-NOVUM SQ Progesterone/Estrogen Comb. Rx

Manufacturer: Ortho Pharmaceutical Corp.

Composition: 14 tablets—mestranol 0.08 mg.

6 tablets—mestranol 0.08 mg.

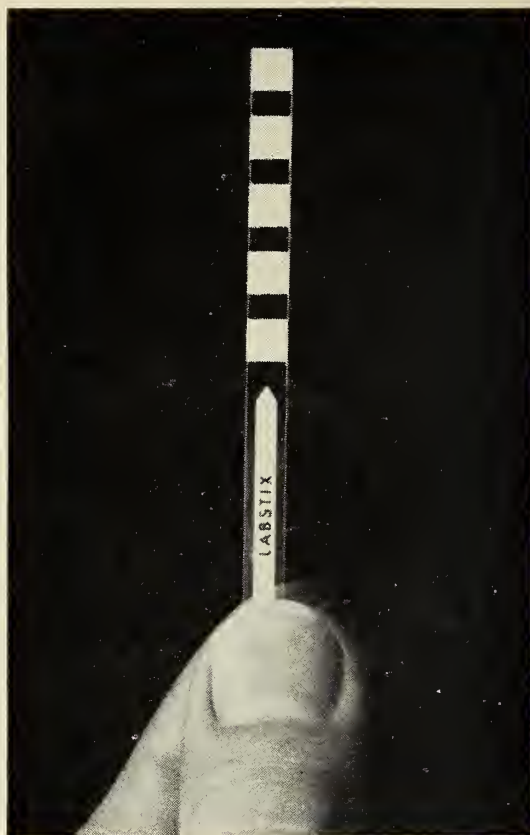
norethindrone 2.0 mg.

Indications: Oral contraception.

Contraindications: Patients with known or suspected malignancy of breast or reproductive system, liver dysfunction or disease, thrombophlebitis or pulmonary embolism, history of cerebral vascular accident, undiagnosed vaginal bleeding, pregnancy, lactation.

Dosage: One white tablet every evening, starting on the fifth day of the menstrual cycle, for 14 days. Then one blue tablet every evening, for 6 days.

Supplied: 20 and 60 tablet Dialpak.



Take five...

LABSTIX® provides 5 important urinary findings*—on a single reagent strip! That's *more* information than you can get from any other single reagent strip. You know the results in just 30 seconds—while the patient is still in your office—and readings are reliable and reproducible. **LABSTIX** is easy to handle, too. Never goes limp, even when wet, because it's made with clear, firm plastic. And results with **LABSTIX** are easy to read—color contrast between the test areas and the transparent plastic is clearly defined. An unexpected "positive" from testing with **LABSTIX** may help in detecting hidden pathology before marked symptoms are manifest.

*Blood; ketones; glucose; protein, and pH.

AMES COMPANY

Division Miles Laboratories, Inc.

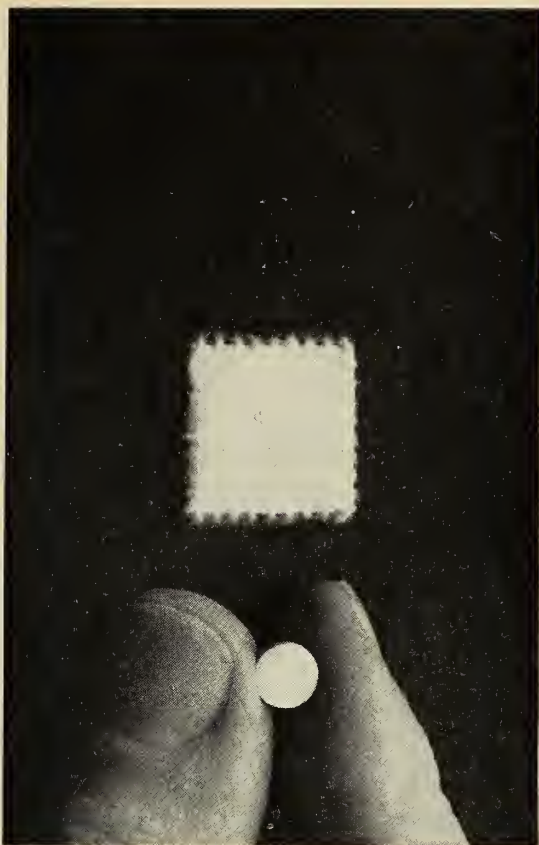
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Note: **AMERICAN HOSPITAL FORMULARY SERVICE**
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...Plus one

You can extend your testing scope by including ICTOTEST® Reagent Tablets, the 30-second determination for bilirubinuria—which can be an early sign of obstruction of the common bile duct, infectious hepatitis, or other liver disease. This test is also useful for detecting liver damage from carbon tetrachloride and other halogenated hydrocarbons used as industrial and household solvents. Positive findings with the urine-testing team of LABSTIX and ICTOTEST can represent significant guides to patient management in many clinical situations. "Negatives" may help rule out suspected abnormalities over a broad clinical range and are important for the patient's record.

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President's Page

(Continued from page 648)

could to fight and to change and to alleviate many of these conditions for the good of medicine.

At the end of my talk, I was asked by one of the doctors, "how do you know what I need or how do you know what my problems are, how can you speak for me when you don't know what I am concerned about?" My answer to this gentleman was very simple. I said to him, my dear friend, if you are a doctor and interested in the practice of medicine and concerned with the future of your society, then you will be perplexed and disturbed by the same problems that disturb me. I asked him, are you in favor of private enterprise in the practice of medicine. Do you believe that the average patient should have the freedom of choice of doctor and that every doctor should have the freedom of choice of patient? If you are of that same belief, then you agree with me, and therefore, I can speak for you in this respect. Further, I said, do you believe that Medicare has been quite a source of disappointment to the medical profession in spite of the fact that it seemingly is running smoothly, but nevertheless, you must agree with me that there are many areas that could be changed and improved. Do you believe that we are having our difficulties with the federal government in this respect? If you believe the same as I do, then I can speak for you. Do you believe also that Medicaid, Title 19, is a more serious problem than Title 18 and that Title 19 requires the attention of all of us? That we must try and work towards the same goals as we have done with Title 18. That we must do direct billing, we must get paid our usual and customary fee, etc. If you agree that this is a problem and concerns you as well as it concerns me, therefore, I can speak for you.

I continued: the Heart, Cancer, Stroke program will become an important part of our consideration over this coming year. The original program as presented by the DeBakey Commission, which stressed centralization about the medical school and would have created problems at the community level, has been entirely reversed. If you agree with me, that this was a worthwhile struggle and effort to improve the

(Continued on page 749)

The Mediatrix Age:

There is a growing senescent body of people on their way to malignant inactivity, who sorely need your interest and direction to help them back to a more active and useful life. There are medicines too, designed to help. One such has proved useful in clinical practice.

"A steroid-nutritional compound (Mediatrix) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging ... This therapy resulted in improvement of 75 per cent of the patients..."

McNeill, A. J.: Clin. Med. 8:518 (Mar.) 1961.

"Mediatrix (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics 12:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

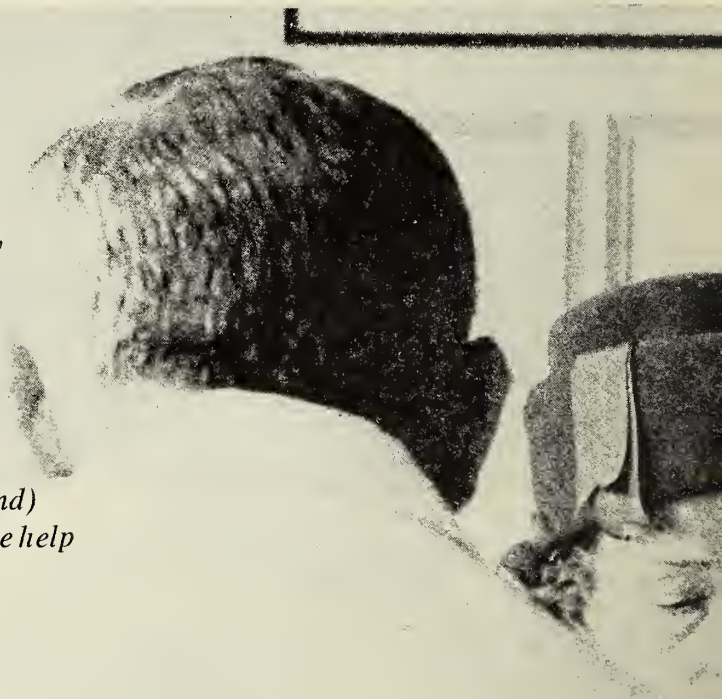
Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied ... The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist 2:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. 12:489 (May) 1964.



Mediatrix®

Designed for the “metabolically spent”

Nutritional reinforcement for those who can't
— or won't — eat properly...balanced amounts of
estrogen and androgen to counteract declining
gonadal hormone secretion and its sequelae of
premature degenerative changes...mild
antidepressant for a gentle “mood” uplift...

The estrogen component in MEDIATRIC is
PREMARIN® (conjugated estrogens—equine),
the natural estrogen most widely prescribed for its
superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a gentle “mood” uplift
through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and
Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from
pregnant mares' urine and standardized in terms of the weight
of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active;
helps relieve general malaise, easy fatigability, vague pains in
the bones and joints, loss of appetite, and lack of interest
usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyl-
testosterone component.

WARNING: Some patients with pernicious anemia may not
respond to treatment with the Tablets or Capsules, nor is
cessation of response predictable. Periodic examinations and
laboratory studies of pernicious anemia patients are essential
and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast ten-
derness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female*: 3 teaspoonfuls of
Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and
uterus, cyclic therapy is recommended (3 week regimen with
1 week rest period—Withdrawal bleeding may occur during
this 1 week rest period).

In the male: A careful check should be made on the status
of the prostate gland when therapy is given for protracted
intervals.

SUPPLIED: No. 910 — MEDIATRIC Liquid, in bottles of 16
fluidounces and 1 gallon. No. 752 — MEDIATRIC Tablets,
in bottles of 100 and 1,000. No. 252 — MEDIATRIC Cap-
sules, in bottles of 30, 100, and 1,000.



Mediatrix®
steroid-nutritional compound

AYERST LABORATORIES, NEW YORK, N. Y. 10017 • Montreal, Canada





PREVENTION OF Rh ISOIMMUNIZATION WITH Rh IMMUNOGLOBULIN

It has long been known that passive antibodies can suppress the formation of active antibodies against an antigen. Dr. Vincent Freda and his colleagues at Columbia University College of Physicians and Surgeons have employed this immunologic principle in studies aimed at the prevention of erythroblastosis in infants born to Rh negative mothers.

Freda first tested this theory on Rh negative male volunteers from Sing Sing Prison in separate trials in 1962-1963 and 1963-1965.

The test group of Rh negative volunteers was given Rh immunoglobulin (fraction II gamma globulin) by intramuscular injection. After 24 hours this group was challenged with Rh positive blood, given intravenously. Both injections were repeated monthly for five months. The control group of Rh negative volunteers received Rh positive blood at monthly intervals for five months. No Rh immunoglobulin was given. None of the volunteers in the test group who received Rh immunoglobulin developed active antibodies, but 66.6 percent of the controls developed anti-Rh antibodies.

In April, 1964, the first clinical trials were begun on Rh negative mothers at Columbia Presbyterian Medical Center, New York, and at the Memorial Hospital at Long Beach, Cal. Dr. Freda followed

471 Rh negative mothers who were at risk of immunization by an Rh positive fetus. Rh immunoglobulin was given to 174 mothers, while 171 mothers served as controls. Both groups were followed for a period of 6 to 18 months after delivery.

None of the 174 mothers protected by Rh immunoglobulin were found to be sensitized to Rh antigen, while 20 of the unprotected mothers in the control group were sensitized. Of 21 mothers given Rh immunoglobulin who subsequently became pregnant for a second time, all remained un-sensitized and 15 delivered a second Rh positive unaffected infant. In contrast six of the first 15 mothers in the control group who delivered a second Rh positive baby were Rh immunized (sensitized) and their infants were affected.

If additional studies corroborate the important findings of Dr. Freda and his colleagues, the prevention of erythroblastosis will have become a reality. Exchange transfusions and intra-uterine transfusions for erythroblastosis due to Rh incompatibility may be reduced or eliminated in the future.

Reference

- Freda, V. J. Gorman, J. G., Pollach, W. Robertson J. G., Jennings, E. R., and Sullivan J. F., Prevention of Rh Isoimmunization: J.A.M.A. 199, 140, 1967.

Harvey Kravitz, M.D.

President's Page

(Continued from page 745)

situation, then you will agree that I fought for you as well as for myself. The program funds of this Heart, Cancer, Stroke program are earmarked solely for education of the physician, para-medical personnel and the lay people. This is a far cry from the original planning by the DeBakey Commission.

I then said to him, my dear friend, do you feel that we have a concern about the image of the doctor, that we are being criticized by the press, radio, television. That we are accused of not wishing to take care of the people who need medical care, that we won't make house calls, that we are only interested in the financial aspects of medicine rather than the welfare of the human being. If you will agree with me that this exists and that there is this problem that we must solve, that we must refute, we must reply and answer, then you will agree with me that I have worked for you and fought for you as well as for myself.

I then continued: There are many other problems that confront medicine every day that require the cooperation of all of us.

Defeatist and acquiescent attitudes of many doctors resulted in lack of interest in the fast changing face of medicine today. The doctors are not a cohesive group. They're not together in either opinion or policy. What we need is a good stimulant for a faltering society membership. We must impress our colleagues that we need their cooperation, we need their help. Yes, criticism is in order, but criticism on the constructive basis rather than destructive basis. We have these problems which will confront us many more years to come, but unless we are together, unless we are properly organized, unless we are willing to go before our Congressmen who represent us in Washington and at the state level, unless we are willing to work as a unit, progress is going to be slow and may be to the detriment of the medical society and the profession.

I'm not particularly interested only in what the results of this lethargy may mean to the society itself, I am concerned about the welfare of the people of this country whom we attend. I'm interested in taking care of people regardless of whether they

(Continued on page 751)



Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy.

Emetrol offers prompt and safe relief. Local rather than systemic

action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.¹

*As shown by *in vitro* studies.

1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.



WILLIAM H. RORER, INC.
Fort Washington, Pa.



Emetrol®
phosphorated carbohydrate
solution
emesis control

Socio-Economic News (Continued from page 704)

usually carry a \$50 or \$100 deductible clause. A Depositor Forgery Bond, with no deductible, covers losses from forged checks and unauthorized use of credit cards by means of your forged signature. You can also insure against expenses from a lost card by adding a rider to a homeowner's policy already in effect.

States Given More Federal Funds Leeway

Illinois Department of Public Health will enjoy greater flexibility in applying federal funds to meet the state's health needs. A new federal law says funds from Washington can be used under a predetermined comprehensive plan to meet state problems of highest priority. Previously, the state was required to spend fixed amounts of specific categories of health needs.

ETHICAL RESPONSIBILITIES IN PRESCRIBING DRUGS AND DEVICES

It is unethical for a physician to be influenced in the prescribing of drugs or devices by his direct or indirect financial interest in a pharmaceutical firm or other supplier. It is immaterial whether the firm manufactures or repackages the products involved.

It is unethical for a physician to own stock or have a direct or indirect financial interest in a firm that uses its relationship with physician-stockholders as a means of inducing or influencing them to prescribe the firm's products. Practicing physicians should divest themselves of any financial interest in firms that use this form of sales promotion. Reputable firms rely upon quality and efficacy to sell their products under competitive circumstances, and not upon appeal to physicians with financial involvements which might influence them in their prescribing.

Prescribing for patients involves more than the designation of drugs or devices which are most likely to prove efficacious in the treatment of a patient. The physician has an ethical responsibility to assure that high quality products will be dispensed to his patient. Obviously, the benefits of the physician's skill are diminished if the patient receives drugs or devices of inferior quality.

Inasmuch as the physician should also be mindful of the cost to his patients of drugs or devices he prescribes, he may properly discuss with patients both quality and cost.

Adopted by the Judicial Council, American Medical Association, March 12, 1967.

President's Page

(Continued from page 749)

can afford to pay or not. I am sure that the medical profession as a whole is dedicated towards that philosophy. I feel confident that the doctors today are just as dedicated and just as wholehearted in their attitude towards the sick as the doctors of yore. I do hope that this lethargy, I do hope that this feeling of apathy will disappear and that all of us together will work towards a goal for better medicine, for a healthier nation.

CAESAR PORTES, M.D.

Abortion Law

(Continued from page 693)

36. Nobuo Shinozaki, M.D.: The Family Planning Movement in Relation to the Level of Living and Abortion in Japan—From the View Point of Quality of Population, *Supra* 25, pp. 630-633.
37. Plan Your Children for Health and Happiness. Planned Parenthood, New York, August 1963.
38. *Supra* 5.
The seriousness of the psychiatric sequelae of abortion are reemphasized in a recent article: Prof. E. W. Anderson (Emeritus professor of psychiatry, University of Manchester, England): Psychiatric Indications for the Termination of Pregnancy, *World Medical Journal*, 13:81-83, May-June 1966.
39. Joseph B. DeLee, M.D.: *The 1927 Year Book Of Obstetrics And Gynecology*.
40. *Ibid.* *The 1940 Year Book Of Obstetrics And Gynecology*, p. 69.

The Doctor's Library

ATLAS OF VASCULAR SURGERY 2nd Edition by Falls B. Hershey and Carl H. Calman. C. V. Mosby Company, St. Louis, Mo. 318 pages, 90 illustrations—\$19.50.

The senior author of this atlas is well known to many Illinois physicians who admire him professionally and personally. Since the appearance of the first edition of this volume in 1963, he has served as Chief of Surgery at Chicago's Michael Reese Hospital and it was only during the past year that he returned to practice surgery in St. Louis. His reputation as a straight thinking surgeon is reflected in his book which unlike similar atlases has an informative text. The direct attack upon vascular problems which is espoused is factually correct and reflects experience and thoughtfulness.

Many of the rough features of the first edition have been smoothed for the present volume. In addition, it has been strengthened and augmented by new and necessary material in some cases such as

(Continued on page 753)

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OBITUARIES

***Dr. Andrew J. Boston**, Centralia, died Feb. 22 at the age of 88. He served as president of the Edwards County Medical Society for a number of years and was a past president of the Albion Rotary Club. He became a member of the Illinois State Medical Society Fifty-year club in 1956.

***Dr. Edward A. Christofferson**, Oak Park, died March 16 at the age of 81. A member of the Illinois State Medical Society Fifty-year club since 1962, he was on the staff of West Suburban Hospital for 41 years and Cook County Hospital for 21 years.

***Dr. Cecil C. Cooper**, Oak Park, died April 1 at the age of 54. He was on the staff of West Suburban Hospital, Oak Park, and was the school doctor for Concordia Teachers College, River Forest.

***Dr. Leland J. Farlander**, Kankakee, died April 1 at the age of 59. He was chief of staff in the Riverside Hospital for two years, and a past president of the Kankakee County Medical Society.

***Dr. Donald F. Farmer**, LaGrange, died March 19 at the age of 52. Dr. Farmer was president of the Medical Directors Club of Chicago and was a fellow of the International College of Surgeons.

***Dr. Harold Gomberg**, Miami Beach, died March 28 at the age of 82. He had been a physician in Chicago since he graduated from the Loyola School of Medicine in 1916. He also had owned and operated Dr. Gomberg's Nursing Home.

Dr. Alois Hrasky, Belleville, died March 7 at the age of 36. He did his internship at St. Louis University Hospital and practiced general surgery at St. Mary's Hospital and Christian Welfare Hospital, East St. Louis; Centerville Hospital, Belleville Memorial Hospital and St. Elizabeth's Hospital, Belleville.

***Dr. Arthur Everett Joslyn, Sr.**, Melrose Park, died March 27 at the age of 86. He had been associated with Westlake Community Hospital since it opened in 1927. At the time of his death he was also on the staff of Gottlieb Memorial Hospital and had formerly been on the staffs of West Suburban and Oak Park Hospitals. Dr. Joslyn was a member of the Illinois State Medical Society House of Delegates for many years.

Dr. Leonard C. Lund, Jackson, Miss., died March 4 at age of 65. Dr. Lund, a psychiatrist, was born in Galesburg and was a veteran of World War II.

***Dr. Robert A. Milroy**, La Grange Park, died March 29 at the age of 51. He was a radiologist at Hines Veterans Hospital during the last year.

Dr. Joseph Cleve Moore, Hoopeston, died March 6 at the age of 81. He was a past commander of the American Legion Post and president of the Rotary Club in Hoopeston.

***Dr. Miroslaw Siemens**, Chicago, died March 14 at the age of 82. A physician and surgeon in Chicago for more than 50 years, he was on the surgical staff of Roseland Community Hospital and for 40 years was surgeon for the Nickel Plate Railroad.

Dr. Daniel Lytle Stormont, 66, died April 1. A specialist in internal medicine, he had practiced in Evanston for 38 years. A veteran of World War I, he was a former lieutenant in the medical reserves.

***Dr. Jacob J. Teplinsky**, Highland Park, died March 21 at the age of 36. He was in charge of a psychiatric ward at Hines Veterans Hospital.

Dr. Harold H. Wise, Chicago, died March 25 at the age of 55. He practiced for 21 years as a physician and surgeon and he was on the staff of Roseland Community Hospital.

**Member of Illinois State Medical Society.*

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The Doctor's Library

(Continued from page 751)

that on catheter embolectomy. Unfortunately, though much that is new has been added, the authors have had difficulty with deletion of obsolete techniques such as the retrograde flush and the seldom practiced direct aortic embolectomy. But this is minutia; the overall presentation is excellent and just right for the surgeon who must practice vascular reconstructions on an irregular basis.

Perhaps the greatest liability of atlases of technique is that they necessarily present method without value judgment. Similarly, in rapidly changing fields such as vascular surgery, important innovations may be omitted entirely. This has happened in this volume where space limitations have prevented extensive explanations regarding choice between techniques. For example, most surgeons would disagree with the flat statement that "side-to-side shunts are preferred" in porta-caval anastomosis whenever feasible. But this is a fault of the atlas format in general, not of this volume in particular.

This second edition is welcome and is a credit to the now well accepted surgical field of vascular reconstruction. Its com-

fortable size and clear printing will be received well by all who study at the end of a long operating day. This includes residents in all years of training and practicing surgeons who choose to reconstruct arteries rather than to perform amputations.

John J. Bergan, M.D.

SURGICAL APPROACHES TO THE NECK, CERVICAL SPINE AND UPPER EXTREMITY. Emanuel B. Kaplan, M.D., Illustrated by Robert Demarest, May 9, 1966. W. B. Saunders, Philadelphia—London, 246 pages. \$11.50.

The author has utilized his experience in anatomy as the foundation for this book on Surgical Approaches to the Neck, Cervical Spine and Upper Extremity. The material is presented in a concise manner, and the illustrations are informative and clear. A brief anatomical consideration is presented in the region of the neck and cervical spine.

It is not the intention of this book to describe individual surgical techniques, as stated by the author, but to review the multiple surgical approaches used for visualization of areas of current surgical importance and the anatomical relation-

(Continued on page 755)

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Days of Our Years

(Continued from page 724)

"Chicago has the Heritage of Epilepsy." No matter what direction I look there are Chicago Neurological Society members at work in the study of this symptom. To the north there is Frank Millen, Meyer Brown, Gordon Millichap, Luis Amador, Joe Tarkington, Charlie Textor, Ben Kesert, Joe Cascino, and Seymour Diamond. To the South there is Doug Buchanan, Joe Evans, Dick Richter, Sid Schulman, Sean Mullen, the two Manfredis, Paul Rosenbluth, Eli Tobias, Irving Sherman, Milt Tinsley, Josh Spiegel, the two Vorises, and the speaker. As I look to the West there is Joe Luhan, Beau Johnson, Bob Tentler, Art Arnold, Kevin Barron, Arch McCoy. As I look to the East there is Alex Arieff, Hal Koenig, Paul Bucy, Don Ruge, Nick Wetzal, Rol Mackay, Ben Boshes, and Joel Brumlik. And in "Center City" there is Eric Oldberg, Erna and Fred Gibbs, Maynard Cohen, Oscar Sugar, Orville Bailey, Percival Bailey, Herb Grossman, John Garvin, Jack Drori, J. Hartmann, Ben Lichtenstein, Hal Lawn, Sherman Kaplitz, Tony Raomondi, and Jim Toman. And then, there are those who were here that left for other areas to include Charlie Barlow, Ralph Gerard, Bill Gustafson, Don Layton, Warren McCulloch, and Earl Walker. And there are others who are interested in epilepsy here in Chicago for I can not name them all. And so, the work goes on and on.

There was hardly a meeting this year during my administration as President of the Chicago Neurological Society in which the convulsive state was not discussed, medically or surgically. Especially was the latter reported on by Tony Raomondi and his "disciples" or by Sean Mullen. New theories were promulgated, new drugs were reported. many promises were made, and I know that they will be implemented in the future. Those who have made the promises—are more than capable of keeping them.

Now as I gaze over the audience, I see the new and younger members who are prepared to carry on the work that we have started and I know that the heritage of epilepsy will be perpetuated.

And so, the 1965-66 season for the Chicago Neurological Society comes to an
(Continued on page 755)

Days of Our Years

(Continued from page 754)

end. And I look back on this pleasurable year which raced by so quickly and I must say again that I was pleased. And so, my thoughts must again revert to that song I love so well, "It Was a Very Good Year."

The Doctor's Library

(Continued from page 753)

ship of different structures under variations occurring with changes in position.

The text is easy to read for the house staff or physician interested in learning these anatomic-surgical variations and what to expect in individual approaches.

It is suggested that additional reading be done to cover techniques underemphasized by the author.

Gabriel A. Lorenzo, M.D.

ROENTGEN SIGNS IN CLINICAL PRACTICE—

Two Volumes by Isadore Meschan, M.D.
W. B. Saunders Co., Philadelphia, 1966.

A resident entering the study of diagnostic radiology usually finds himself overwhelmed by the vast scope of his chosen field. This two volume study should be a great help in an initial orientation. Following the format of his earlier editions, Dr. Meschan systematically outlines, with liberal use of excellent line drawings, basic radiological principles as applied to the skeletal system, chest, G.I., and G.U. A section explaining the basic radiological and physical problems which may be encountered is concise and to the point. Most of the newer clinical entities are included with a brief discussion of their diagnostic highlights.

The only failing that these books have is an unevenness in the quality of the roentgenographic reproductions, some of which would be difficult for the neophyte to interpret; however, most of the radiographs demonstrate the pathology.

The author doesn't attempt to cover the field of arteriography as this is basically a more advanced study and is properly taken up elsewhere.

I highly recommend these volumes to residents in radiology and others who are interested in obtaining basic insights in the field of radiological diagnosis.

Leon Love, M.D.

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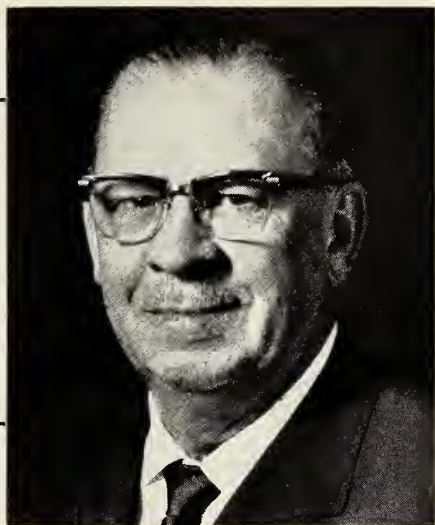
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The president's page



Newton DuPuy, M.D.

The Illinois State Medical Society is the fourth largest medical society in the United States; certainly it is one of the most important. Illinois will shortly begin its celebration of 150 years of statehood and in this sesquicentennial year I think I should bring to you a brief sketch of the Illinois State Medical Society in the past 126 years.

To the best of my knowledge it all began the 9th of June, 1840, in Springfield, where a group of physicians gathered to conceive a new organization. Their main concern was the charlatans practicing "within the very temple of Aesculapius," as they put it. But rather than take the negative course of making war against the quacks they decided to pursue the positive aims, and I quote: "to benefit the people, instruct the unlearned, inform ourselves and elevate the entire profession above all mercenary considerations to a station of superior mental, moral, and medical excellence."

We have only scanty records of the 10 years during which the society functioned before it was reorganized. But I will mention one founder whose fervor did not diminish and whose name appears again and again. He is Dr. John Todd of Springfield, an uncle of Mary Todd Lincoln. As a surgeon back in the War of 1812, Dr. Todd was among a group of captives whose scalps were offered to the Indians by their British captor. Luckily for us, Dr. Todd was one of the few to escape this hair-raising end.

He lived to help found our society and to be its president in 1847.

The history of Illinois medicine up to 1850 is preserved in Volume I of a projected series entitled *History of Medical Practice in Illinois*. Embossed on the cover of Volume I is the seal: "I.S.M.S. founded in 1850." The seal on Volume II reads: "I.S.M.S. founded in 1840."

Volume II carries the history through the medically productive years between 1850 and 1900. Of its latter years, our beloved Dr. Nicholas Senn said at the society's 1893 convention, "We live in an age of great unrest in medical literature. Books written only yesterday are old today." Indeed, they were spectacularly outdated by Pasteur and Lister, by Virchow's cellular pathology, and by acceptance of the germ theory of disease.

For us as a society, one man holds at center stage throughout this period, Dr. Nathan Smith Davis. Already the founder of the American Medical Association, he strode onstage here in 1849 when he left New York behind to take the chair of physiology and pathology at Rush Medical College in Chicago. In the Illinois State Medical Society, his name is almost synonymous with the organization. In 1855 he was made president and after his term of office ended he became the first permanent secretary. He held that office for a total of 17 years.

(Continued on page 780)



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Regarding Increased Resistance—During the last eight years, 5700 strains of *N. gonorrhoeae* have been isolated and tested for sensitivity to penicillin and sulfadiazine in the Public Health Laboratory (Toronto). ⁽¹⁾ In the six-month period of January to June, 1966, no less than 18.8 per cent of the *N. gonorrhoeae* strains isolated required 1.0 unit of penicillin per ml to inhibit their growth; and 8.6 per cent required more than 1.0 unit. In contrast, only eight years ago, 98 per cent of the isolates were sensitive to 0.1 unit of penicillin or less.

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*The above studies utilized DECLOMYCIN in a variety of dosage schedules. The recommended adult dosage of DECLOMYCIN is 600 mg divided into two or four doses daily.

1. Amies, C. R.: Development of Resistance of Gonococci to Penicillin: An Eight-Year Study. *Canad. Med. Ass. J.* 96(1):33 (Jan.7) 1967. 2. Garagusi, V. F.: Antibiotic Review. *Amer. Fam. Phys.* 11:61 (Nov.) 1966. 3. Sokoloff, B.: Demethylchlortetracycline Therapy in Acute Gonococcal Urethritis. *Clin. Pharm. Ther.* 6:350 (May-June) 1965. 4. Allison, J. R., Jr.: Demethylchlortetracycline Hydrochloride in the Treatment of 267 Patients with Acute Gonorrhea: Results and Evaluation. *Antibiot. Chemother.* 11:454 (July) 1961. 5. Vanderstoep, E. M.; Matheson, T. E.; Moore, M. B.; Short, D. H., and Knox, J. M.: A Comparison of Penicillin and Demethylchlortetracycline in the Treatment of Acute Gonorrheal Urethritis in the Male. *Southern Med. J.* 57:201 (Feb.) 1964. 6. Marmell, M. and Prigot, A.: The Therapeutic Value of Demethylchlortetracycline in Gonorrhea, Lymphogranuloma Venereum, and Donovanosis. *Antibiotics Annual*, 1959-1960, p. 457. 7. Pochi, P. E. and Strauss, J. S.: The Single Dose Treatment of Acute Gonococcal Urethritis with Demethylchlortetracycline. *Antibiot. Med.* 8:75 (Feb.) 1961. 8. Greaves, A. B.: Demethylchlortetracycline in the Treatment of Venereal Disease. Unpublished data on file, Medical Research Section, Lederle Laboratories.

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Side Effects—Gastrointestinal system—*anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani.* Skin—*maculopapular and erythematous rashes.* A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—*rise in BUN,* apparently dose related. Hypersensitivity reactions—*urticaria, angioneurotic edema, anaphylaxis.* Teeth—*dental staining (yellow-brown)* in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood (up to 12 years). Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlor-tetracycline HCl.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



LEDERLE LABORATORIES, A Division of
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President's Page

(Continued from page 777)

Some of his writings make good reading today! Consider this definition, delivered 102 years ago to the 1865 convention: "The science and art of medicine may be defined to be the application of the facts and principles embodied in the various departments of natural, economical and metaphysical sciences to the elucidation, prevention and cure of diseases."

Volume II of the *History of Medical Practice in Illinois* ends at 1900, four years before Nathan Davis' death. I think it is time to make a cut-off: COMPILE and print Volume III of the *History of Medical Practice in Illinois*.

NEWTON DUPUY, M.D.

Finch Named Head of CMS Board

The election of Herman M. Finch as chairman of the Board of Trustees of The Chicago Medical School has been announced by the board.

Action taken at the same meeting also officially confirmed the establishment of Mount Sinai Hospital Medical Center as the prime base teaching hospital for CMS.

Finch, head of Herman M. Finch and Associates, Industrial Relations Consultants, succeeds Lester N. Selig, retired chairman of General American Transportation Corporation, who has retired from the board.

"The goal of our board is to help to amalgamate the best efforts of both The Chicago Medical School and its Institute for Medical Research, to interrelate the two functions so that they will continue to work for the common good of environmental health problems.

"Our task is to meet the serious shortage in the health professions, without sacrificing our very high standards of education and research. We are led in the establishment of these high standards by the accrediting agencies, including the American Medical Association and the American Association of Medical Colleges, which we salute and applaud."

Born July 7, 1914, Finch was raised in Omaha, Nebraska. He received his undergraduate education at the Municipal University in Omaha and the University of Chicago. In 1937, he received his master's degree in economics from Columbia University.



The Use of Psycho-active Drugs in Children

By JOHN S. WERRY, M.D./URBANA

Because of a relatively greater shortage of psychiatrists interested in children and an understandably greater reluctance to use new drugs (i.e. stimulants and tranquilizers) in children, the whole field of pediatric psychopharmacology is in general in a much less developed state than the comparable adult area. The number of methodologically adequate studies is so few that the reviewer finds himself maneuvered into the unfortunate position of having to make certain dogmatic statements which he is unable to support adequately with solid, empirically derived knowledge.

Most of the problems of pediatric psychopharmacology are similar to those encountered in adult psychopharmacology with the addition of a few which are peculiar to, or heightened by, the biological, sociological, and ethical consequences of working with immature human beings. These problems are:

(1) Psycho-active agent must be safe—in general, the three basic types of drugs (vide infra) appear to be relatively non-toxic.

This paper is based on a talk given at the 1966 annual meeting of the Illinois State Medical Society. Its preparation was supported by Public Health Service Research Grant MH-07346 from the National Institute of Mental Health. Dr. Werry is Research Psychiatrist at the Children's Research Center and Assistant Professor of Psychiatry, Department of Psychology, University of Illinois, Urbana.

(2) The drug must be of demonstrable efficacy—it is now possible to delineate, albeit crudely, certain conditions or symptoms in which the exhibition of psychopharmacological agents may be of value.^{1,2,3}

(3) There should be no interference, particularly if the administration of the drug is to be long term, with physical, psychological, or intellectual development—there is little evidence to date to suggest that in the dosage in which they are commonly administered that the well-established drugs have detrimental effects in these areas.⁴

(4) The drug should not produce addiction or psychological dependence—to date, there is no evidence that this is a significant problem in children who are younger than adolescent.

(5) It is necessary to know what effects the age of the patient has on both relative dosage level and in certain cases, the actual clinical effect of the drug—there is already evidence that certain drugs have profoundly different effects in different aged children and that some age groups have a high tolerance to certain drugs, necessitating adjustment of dosage.

(6) The effect of mental age or intelligence must be evaluated—certain studies have shown that great responsivity can sometimes be produced in children of lowest mental age.⁵

(7) Cerebral Status (brain damage or dysfunction) which is so often a differen-

tial diagnostic problem in the behavior disorders of children, probably influences the effect of certain psycho-active agents^{2,6} though there is yet no clear evidence to this effect.

(8) The effect of the drugs upon the work of childhood, namely learning, must be taken into account—to date, the few studies which investigated this area have in general shown that drugs are without significant detrimental effect upon the learning process.^{3,5,7,8,9}

TYPES OF PSYCHO-ACTIVE AGENTS

Though new psychopharmacological agents are appearing with increasing frequency, this reviewer believes it is both prudent and clinically most productive for the practicing physician to utilize only three or four basic drugs, most of which have been extant for at least 10 years. None of the drugs introduced since this period of time can, in the present state of knowledge, be represented as significant additions to the pharmacopoeia. Practicing physicians should acquaint themselves thoroughly with one of the three or four basic psycho-agents (*vide infra*) and leave the exploration of newer drugs to properly qualified investigators who usually take from three to five years after the introduction of the drug to explore both its efficacy and short-term safety. The long-term safety of a drug, i.e. with chronic administration, usually requires a minimum of a 5-year period for its establishment. It should be borne in mind that children, unlike adults, do not have the freedom of choice as to whether or not they will take medication, and they therefore require greater protection.

A. Psycholeptics (Tension-reducing drugs).

1. Sedatives and Minor Tranquilizers.

Phenobarbital (3 to 6 mg/kg/24 hrs.) and other barbiturates are inexpensive and of proven safety. They warrant a first trial, especially in less serious conditions, except in children who have organic brain damage or the hyperkinetic syndrome where they may greatly aggravate the symptomatology. An occasional child is made irritable or depressed by phenobarbital. There is little evidence to support the contention that the newer sedatives such as meprobamate, hydroxine, chlordiazepoxide or diazepam are either as effective as, or in

adequate dosage, less free of intoxication effects, than the barbiturates.¹⁰ Diphenhydramine has been reported² to be effective in doses between 2-10 mg/kg/24 hrs. in pre-adolescent children, but the present author has not had the same success as reported by the Bellevue group.

II. Major Tranquilizers. (Neuroleptics)

The phenothiazine group of drugs are of proven utility in certain conditions, but produce a significant percentage of minor though troublesome side effects, particularly photosensitization, dystonias, Parkinsonism, and a variety of disturbances of the autonomic nervous system. Less common side effects, apparently rare in children, are seizures, retinal pigmentation, blood dyscrasias, and jaundice. The adverse effects of chronic administration of high doses of chlorpromazine, namely disturbances of pigment metabolism, are only just beginning to appear.^{11,12} Fortunately, cases reported to date have usually been receiving doses of this drug in excess of 7 mg/kg/day which is at the very upper limit of acceptable dosage of this drug for children,² and these particular complications have not yet been reported in children. However, inasmuch as chlorpromazine is the oldest of the phenothiazines having been used for almost 10 years, it should be a warning against chronic administration and high dosage levels with psycho-active drugs.

B. Psychoanaleptics (Mood elevators).

1. Stimulants.

These are among the most useful group of drugs in children's behavior disorders.^{3,6,9,13,14} Paradoxically, however, these drugs are used not for their stimulating effect, but because in younger children they seem to have a sedative action. It is unclear at the moment whether this paradoxical sedative effect is restricted to certain diagnostic groups or to certain age levels. There seems little to choose between dextroamphetamine (dose range .1 to .4 mg/kg/24 hrs.) and some of the newer sympathomimetic stimulants such as methylphenidate.^{2,3} Though the amphetamine group of drugs is known to be addicting in adults and adolescents, there do not seem to be any reported cases of this in children, presumably because adults are able to control the child's intake of medication, or perhaps because the euphorizing effect seems to be absent. Side effects include irritability, in-

somnia, anorexia with significant weight loss, and excitement.

II. Anti-depressants.

Inasmuch as depression, particularly in the form which is amenable to antidepressants, does not occur in children and but rarely in adolescents, the anti-depressants which are so useful in the treatment of severe depressions in adults, have no real role to play in childhood psychopharmacology. An exception to this is, however, the use of imipramine in the treatment of enuresis where it is almost certainly acting not as an anti-depressant drug, but as an inhibitor of the autonomic nervous system (retention of urine is not an uncommon complication of imipramine therapy in older adult males). The evidence of the efficacy of imipramine in enuresis, particularly in children, can only be described as conflicting, and the dosage required (up to 200 mg per day) can only be described as very high.¹⁵ Furthermore, in the author's own experience, as with other drugs whose site of action is on the autonomic nervous system, tolerance develops and it is necessary to increase dosage. Also, when the drug is withdrawn, the patient usually relapses. Side effects of imipramine are irritability, headaches, dizziness, insomnia, and gastro-intestinal upsets.¹⁵

C. Psychodysleptics (Psychotomimetics)

This group of drugs (e.g. LSD) which have recently achieved notoriety for their purported use on college campuses, have been tried only on rare occasions¹⁶ in children and, as in adults, have not yet really demonstrated their usefulness.

Clinical Indications

Drugs have been claimed to be successful in a wide variety of conditions all of which can be reduced to the common denominator of symptoms of psychomotor excitation.² Of all symptoms, hyperactivity appears to be the most regularly responsive. Other symptoms purportedly responsive to medication are hyperexcitability, impulsivity, distractibility, and aggressive disorganized behavior.^{1,2,3,8,14,17,18} Also probably responsive to the action of medication though less predictive are anxiety-produced symptoms, such as certain kinds of enuresis,^{19,20} tics, phobias and sleep disturbances. Demonstration of adverse ef-

fects on intellectual functioning in emotionally disturbed children is lacking.^{7,8} There is some tenuous evidence^{3,5,9} that stimulant drugs such as dextroamphetamine may actually produce some slight improvement in intellectual functioning.

Some Rules About The Use of Psycho-Active Drugs

(1) Avoid new drugs, especially those less than five years old. Get to know a barbiturate, a stimulant such as dextroamphetamine, and a couple of phenothiazines such as chlorpromazine and thioridazine which will be found adequate for most conditions which are responsive to psycho-active drugs.

(2) There is merit to place the patient first on a placebo, since very often this will produce surprising therapeutic successes and also enables the separation of genuine side effects of a drug from initial psychological reactions in parent and child to taking medicine. Drugs are a very weak agent in modifying behavior as compared with the overwhelming effect of psychological factors. The utility of drugs in the modification of children's behavior problems is not well established so a proper spirit of conservatism, and skepticism is to be commended.

(3) Check the therapeutic effect of the drug from time to time by either stopping it or substituting a placebo since many apparent therapeutic successes are not due to the effect of the drug or even if they are, they may become self-perpetuating once established.

(4) In general, intermittent (for example five days per week or three weeks per month) is to be preferred to continuous dosage since it should prevent the development of cumulative effects as well as minimizing the development of tolerance.

(5) Do not give potentially harmful pharmacological agents to children where you wish mainly to placate anxious or demanding parents. Placebos have a role to play in this respect.

(6) Do not rush into prescribing active drugs since most children's behavior problems are of relatively short duration. It is often a good idea to wait until a return visit.

(7) Do not prescribe psycho-active drugs except where the condition is sufficiently

(Continued on page 827)



Fig. 1. Painting purported to be that of Gaspar Tagliacozzi (1546-1599). Water color copy by author.

Plastic and Reconstructive Surgery

By FRANK W. PIRRUCCELLO, M.D., F.A.C.S./EVANSTON

Plastic and reconstructive surgery is that branch of medicine which deals with the repairing, altering and transferring of tissue. Its purpose embraces the very quintessence of man's desire to achieve functional and esthetic improvement of himself—despite the fact that he falls short of perfection.

No one can say when plastic surgery began. The only thing certain is that its origin lies somewhere in the Stone Age; it's possible that Fred and Wilma Flintstone were pioneers in this field. In that era man made fundamental discoveries—control of fire, domestication of plants and animals, the use of tools—on which all of civilization has been built.¹

Several papyri devoted to medicine have come down to us. The most valuable of them, named from the Edwin Smith who discovered it, is a roll 15 feet long dating about 1600 B.C. It describes 48 cases in clinical surgery, from cranial fractures to injuries of the spine.²

If one recalls for a moment the early phases of civilization, one is impressed with the numerous methods man has devised for injuring himself. The chariot racers, the primitive engineers' attempts at building structures high above the ground, the first designers of heavy war equipment—all of these people have contributed greatly to progress, and unwittingly to the production of bizarre and multiple injuries to the human body. This trend has continued.

In 1957, an earth-born object made by man was launched into the universe, where for some weeks it circled the earth—this event, second in importance to no other, was another step toward escape from men's imprisonment to the earth.³ Serendipity will undoubtedly produce beneficial discoveries, but there will also be new types of injuries to man.

Gaspar Tagliacozzi (1546-1599), Italian surgeon, published a treatise on Plastic Surgery in 1597, "*DeCurtorum Chirurgia per Institionem*." This was a volume of 298 pages including 22 full page plates.⁴ Although ancient practitioners practiced

transferral of tissues in various ways, Tagliacozzi was the first to organize the material and to practice the art in an orderly fashion. The treatise definitely served as the foundation for growth and development of modern plastic and reconstructive surgery (Fig. 1).

Transferring tissues by means of a pedicled flap pre-dated free transplantation of tissue as a free graft by many centuries. The Italian forearm flap was used in the fifteenth century, the Indian forehead flap was observed in the eighteenth century; but the free skin graft was not reported until the nineteenth century.^{5,6,7}

Halsted, in the second half of the nineteenth century stressed gentleness and aseptic technique in the handling of tissues.⁸ Today free grafts of skin, fascia, cartilage and bone are commonplace. Improved technique in the handling of these tissues has made this feasible. Tremendous strides in anesthesiology and in the facilities supplied by the modern hospital has made this easier.

Autogenous grafts transferred as a free agent from one part of the human body to another area on the same person remains the tried and proved keystone of successful transplantation of tissue.

Homogenous grafts transferred from one individual to another is successful in varying degrees depending upon the tissue used. Homografting is fraught with temporary survival when skin is transferred, and significant absorption is observed when cartilage is used. There are many unanswered questions to the problem of the relationship between homograft to host.

Split Thickness Graft

A split thickness skin graft is removed by splitting the dermal layer of the skin. Varying thicknesses of the dermis are taken with the graft and a portion of the dermis

From the Department of Surgery (Plastic Surgery) Northwestern University Medical School, and Department of Oral Surgery (Plastic Surgery) Northwestern University Dental School.

is left behind so that the donor site will heal spontaneously.

A thin split thickness skin graft is the quickest, most expedient and valuable method by which a large granulating surface can be covered and converted into a closed wound. The thinner the graft, the most certain one is assured that it will "take", provided the recipient area is compatible and capable of supporting growth. The split graft provides large sheets of skin to cover large areas that require tissue replacement. The classic example of its need and use, of course, is the burned individual. Donor sites that have been used for the removal of very thin grafts can be used again in a period of from two to six weeks.

It is axiomatic in reconstructive surgery that tissue requiring replacement be replaced with like tissue in like amounts. Stated differently, in planning reconstruction procedures, one simply plans to put back that which is missing.

Full Thickness Grafts

A full thickness skin graft is a segment of skin which contains the epidermis and the entire thickness of the dermis. It is used in areas where esthetic and functional demands are greater than that obtainable

by a split thickness graft, but less than those required by a pedicle flap. The full thickness graft is subject to less contraction than a split graft. The face is the area where a full thickness graft is used most extensively, especially around the orbit and nostrils.

The full thickness graft is limited in scope for several reasons, the principal reason being the donor site will not heal spontaneously. It must be undermined and approximated if it is small enough. If the donor site is too large for direct approximation, it must be split thickness skin grafted from another suitable donor site. Another difficulty is that a donor site of suitable match and color and texture is difficult to find.

A full thickness graft is adequate in restoring a full thickness loss of tissue of the lower eyelid. On the other hand, a full thickness loss of tissue over the plantar aspect of the foot with exposure of fascia or tendon will require re-surfacing of the foot with a flap. The latter will be required for padding the foot and to render it comfortable for weight bearing. It has a protective function to the underlying anatomical structures.

Pedicle Skin Flaps

Skin flaps are segments of skin containing not only the epidermis and dermis, but

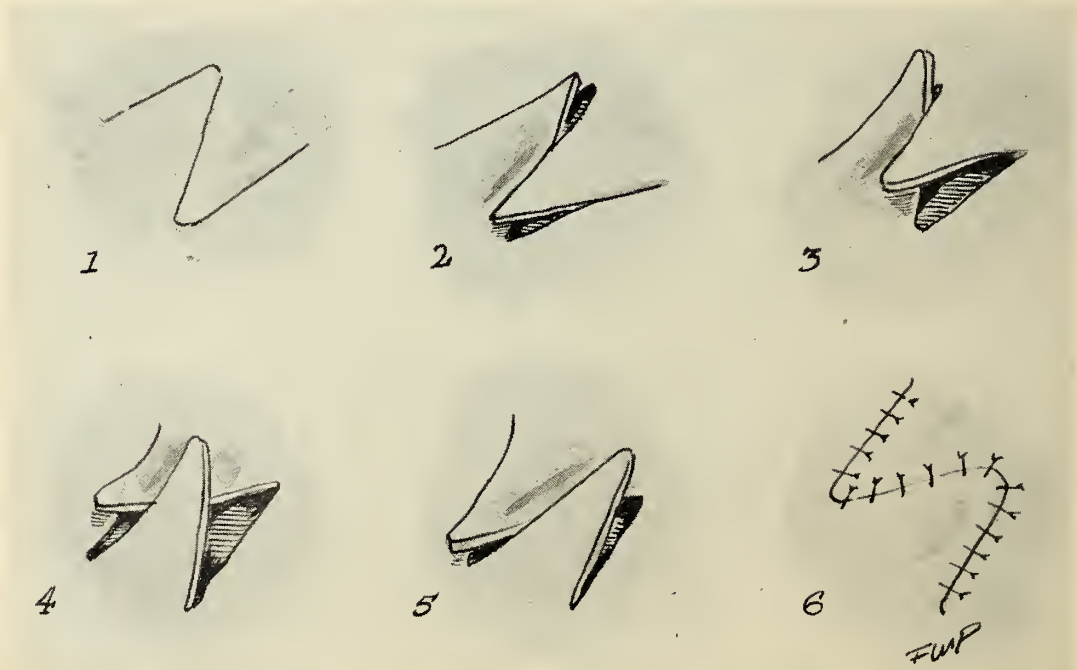


Fig. 2. Demonstration of 'Z' plasty procedure with transposition of flaps.

also containing an anatomical segment of fat. Since it remains attached at one end, it carries with it its own blood supply. Its advantages are, of course, that you not only deliver a quantity of tissue that is required to fill a defect where an equivalent quantity of tissue is missing; but also, it carries a new blood supply to the recipient area. The latter point is especially important in covering an area that has been irradiated.

The disadvantages of flap surgery are that preparation of the flap is usually in stages; it is time consuming, and may require awkward positioning of the patient.

'Z' Plasties

The 'Z' plasty procedure is a method of transposing adjacent flaps, hence changing the direction of tissue tension and relieving the contraction between two points (Fig. 2). This is an excellent procedure to use in recurring cicatricial ectropion of the lower eyelid or to repair a "bow-string" deformity of an extremity or digit. The ordinary 'Z' plasty outline over a contraction band has two triangular shaped flaps extending at angles of approximately sixty degrees from the main line of pull. The flaps are carefully dissected free, making certain that a good thickness of fat remains adherent to the undersurface of the flap. This allows sufficient blood supply to remain intact for survival of the flaps.

A 'Z' plasty can be done in series if a contraction band demands it, hence there is no limit to its application provided the tissue will permit it.

Fascia

Autogenous or homogenous fascia, usually taken from the fascia lata of the thigh is an excellent source of material for use in re-animation of the face. It has been shown that freeze dried fascia of homogenous origin is as good as autogenous fascia in supporting the face.⁹ In our experience, the autogenous fascia removed from the patient himself with a fascial stripper is a quick and efficient method, leaving only a small incision in the upper portion of the thigh. Fascia is used where tendonous type of pull is necessary. It works well in irreversible facial paralysis. Incisions are made at the corner of the mouth and on the upper and lower lip, the face is undermined from the corner of the mouth to meet an incision in the temporal

area. The fascia is strung from the corner of the mouth across to the healthy muscle and then back again to the corner of the mouth repeating the procedure for the lower lip, finally to be anchored again at the corner of the mouth. A strand of fascia is then placed in a subcutaneous tunnel connecting the oral fascia to the temporal area. The masseter or temporal muscle may be used as pedicle transplants.

Cartilage

Autogenous cartilage survives free transplantation by fibrous union, provided it is completely protected by firm and healthy tissue.^{10,11,12} Cartilage cells retain their original appearance. The cells are nourished by diffusion and apparently do not become vascularized like the bone graft. There is often an associated partial absorption of the cartilage in autogenous grafts. Autogenous grafts in younger individuals tend to warp in some cases. Cartilage homografts are successful, but tend to be reduced in mass by gradual absorption as the matrix is invaded by the host tissue. Some cartilage homografts tend to retain their size.

Cartilage grafts of autogenous or homogenous origin are useful in the correction of contour deformities that require rigid structure. They are used to correct depressed nasal dorsums, facial skeletal deformities of any type. Cartilage is used in total or partial reconstruction of the external ear.

Bone Grafts

Autogenous bone grafts with living cells remains the ideal substance for bone grafting. The greater the number of open trabeculae in the graft, the more rapid the invasion of blood vessels by the host. This enhances the chance of "take" in bone grafting. Maximal cell survival in a superior physiological, well vascularized host bed is the important thing. Homogenous bone grafts and calf bone grafts have also been used successfully in selected cases.

Scars And Keloids

A wound cannot heal without the formation of scar tissue. The degree of scar formation is dependent upon a number of variable factors, such as cause of injury, age of patient, location of the scar, direction of the scar and the condition of the skin.

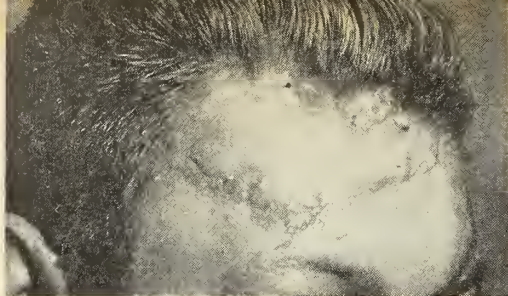


Fig. 3. Pre-operative view of patient presenting traumatic scars of forehead.



Fig. 4. Post-operative view of patient following scar excision and sanding in two stages.

Scars can be painful and unsightly because of adherence to underlying structure such as bone, tendon or nerve (Fig. 3,4). One cannot overly emphasize the need for early and meticulous cleansing of the wound with soap and water, extensive irrigation and removal of foreign material.

Debridement in millimeters with careful trimming of devitalized and contused tissue, careful handling of tissue with skin hooks or fixation forceps contribute to a lessening of scar tissue formation. The use of fine suture materials such as 4-0, 5-0 nylon or silk is important in obtaining optimal results.

After the airway has been established, the patient's general condition stabilized, and appropriate consultation obtained, the immediate repair of the wound can be carried out. The emergent care of wounds should include the following:

1. Scrubbing and removal of traumatic debris to prevent secondary, permanent tattooing.
2. Debridement and repair of laceration.
3. Use of the principle of the "cardinal suture" to realign known anatomical points. Eyebrows, mustaches, wrinkles, and vermilion margins are all-important landmarks used in the placing of the "cardinal suture." It is as foolish to shave off an eyebrow or mustache as it is to smudge an important tactical map during the heat of battle.
4. Evaluation of the patient's immune status, using tetanus antitoxin toxoid when indicated.
5. Facial fractures are diagnosed and treated selectively.¹³

Hypertrophic Scars

A hypertrophic scar is a raised, reddish, thickened, often pruritic type of wound healing. It occurs most frequently in growing children. It occurs when there has been tissue loss—the scar is serving a functional purpose in compensating for tissue loss, by pulling adjacent tissue into the area. This will lead to contracture. This hypertrophic scar is differentiated from keloid insofar

as it does not extend into the neighboring tissue. The hypertrophic scar will eventually show signs of maturation with atrophy. Diminution in the intensity of color as evidenced by whitening and flattening of the scar, is an indication of regression.

Treatment of the hypertrophic scar is usually more satisfactory if signs of regression occur before attempts are made at surgical excision. General health should be good before attempts at excision are carried out. The use of vitamin A, weight loss in the obese, controlling of acne or skin eruptions all contribute significantly.

If there is skin loss, certainly skin replacement will reduce tension in the area. If skin loss is minimal and a contraction band forms across a flexion area or skin cleavage line, a 'Z' plasty or series of 'Z' plasties is indicated.¹⁴ Partial excision of a hypertrophic scar remaining within the confines of the scar is helpful. Partial excision followed immediately by irradiation directly from the operating amphitheatre to x-ray amphitheatre is useful.

Keloids

A keloid is a type of wound healing characterized by a raised, reddish, thick scar that tends to extend into neighboring tissues. They may be pruritic and do not show signs of regression with maturation and atrophy. They are resistant to all forms of treatment and are notorious for recurrence after treatment.

Multiple partial excisions followed by immediate irradiation appears to help in some cases. Certainly it should be attempted in small areas and if satisfactory results are obtained, larger areas can be excised. Triamincinoline injections appear to have some merit.^{15,16,17} Further long-term studies are in progress. Three cases are reported in which keloids were surgically excised and the wound treated several weeks after surgery with bi-weekly applications of 0.5% thio-Tepa ointment, the number of applications ranging from three to 10.¹⁸

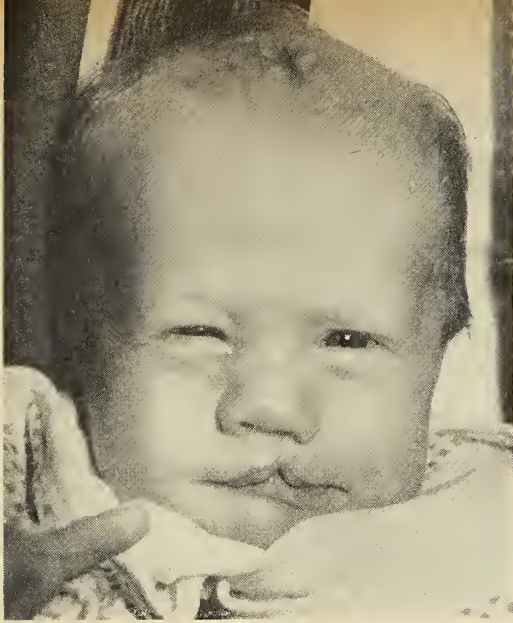


Fig. 5. Congenital cleft lip.

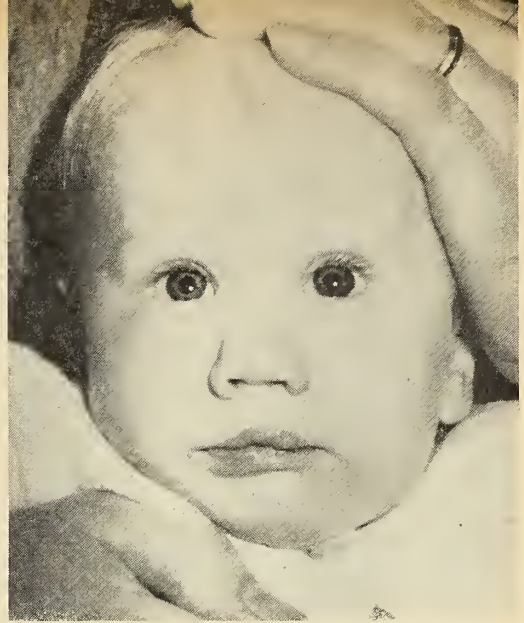


Fig. 6. Repair of cleft lip by modified Hagedorn method.

Cleft Lip And Palate

A cleft lip is an anomaly of the face in which there is either a failure of fusion embryologically of the maxillary and medial nasal processes, or imperfect fusion with subsequent embryonic separation of the involved segments. This results in an abnormal appearance or opening in the lip which is not only esthetically bad, but also seriously interferes with function of the mouth. Embryologically the medial nasal process grows downward more rapidly than the lateral nasal processes. Its infero-lateral corners are rounded and prominent and are known as the globular processes. Later the globular processes come in contact with the maxillary processes on both sides. Subsequent changes are only partly due to fusion of primarily separated "processes." A fusion takes place only during formation of the primary palate and, to some extent during the development of the mandible. In all other regions the grooves separating the facial processes gradually become shallow by proliferation of the mesoderm, and finally disappear. This is of great importance for the explanation and understanding of malformation.¹⁹

A number of pedigrees showing the recurrence of harelip in several consecutive generations have been published. From these the character might be interpreted as a single dominant. In other families both parents of a child with harelip are apparently normal. This fact precludes the single dominant explanation unless there is great irregularity in the expression of genes or unless new mutations occur.

In mice, harelip is hereditary, and, as in man, is found more often in males than in females and more frequently on the left side than on the right. The number of genes and their effects are still undetermined. Differences in intra-uterine conditions seem to play a part in the development of mice.²⁰ Desoxyribonucleic acid appears to provide the universal coding mechanism that synthesizes the amino acids in their arrangements to form a particular protein.

When a child is born with a cleft lip, the following factors have been shown:

1. Unaffected parents in the general population have approximately 0.10 percent to 0.15 percent chance of having a child with a cleft lip.
2. If unaffected parents have a child with a cleft lip, there is a 5.0 percent chance of each subsequent child being affected.
3. If a second child is affected, chances of a subsequent child being affected are 10 percent.²¹

Technical advancements in the repair of cleft lip and palate have made tremendous strides over the past decade. Repair of the lip is usually done as soon after birth as the infant's condition will permit (Fig. 5,6). This is usually within the first few weeks of life. Palate surgery is postponed, under ordinary conditions, until the infant is approximately eighteen months of age. Attention is directed to growth and development of the infant's face, as well as to the problems encountered in the development of his speech.

Modern operative procedures for the correction of cleft lip and cleft palate are, for the most part, refinements of the technics developed by pioneer surgeons in this field. Procedures in use today are generally attributed to Warren, Von Longenbeck, Passavant and Dorrance. The effects of trauma and compression on growth centers of the face have been reported.²²

Today the plastic surgeon has available a number of tested operations and technics which, if utilized properly, can result in satisfactory reconstruction of clefts in the great majority of instances, with a resultant adequate mechanism for normal speech and without the former detrimental effect on the growth of the upper jaw.^{24,25,26,27}

Years of post-operative studies at the Cleft Lip and Palate Institute of Northwestern University suggest that no one procedure for surgical closure is adequate for all types of clefts.²³ Autogenous bone grafts, pushback procedures using nasal mucosal flaps, retropharyngeal cartilage grafts and pharyngeal flaps are useful procedures.²⁴

Pharyngeal Flaps

A pharyngeal flap is a flap composed of mucosa and muscle of the pharynx that is outlined and developed in the superior portion of the posterior wall of the pharynx.²⁸ The flap can be used as a primary procedure when the cleft in the palate is closed, or can be used as a secondary procedure to correct velo-pharyngeal incompetency in a repaired, so-called "short" palate. It is based either superiorly or inferiorly and migrated immediately to the palatal area for the relief of palatal pharyngeal insufficiency. Re-enforcement of the pharyngeal constrictor with loss of nasality determines whether the flap is successful. Individuals are able to close off the communication between the oral and nasal cavity by decreasing the distance the palatal pharyngeal constrictor has to move. There is also some narrowing in the pharyngeal orifice.

Skoog reported 82 cleft palate cases treated with pharyngeal flap. All patients operated on before the age of 10 demonstrated normal speech. Below the age of 20, 97 percent were rated as having acceptable intelligibility compared with 77 percent when the operation had been performed after that age.²⁹

The speech bulb is often used secondarily, the same indications being used as de-

termined for a pharyngeal flap. A speech bulb, in some instances, is a temporary procedure; the bulb gradually being diminished in size as the palatal muscles gradually compensate to "educational hypertrophy to pick up more of the slack." The bulb is gradually made smaller and finally eliminated. A bulb is difficult or impossible to use when there are multiple dental problems that preclude its use on already dangerously impaired dentition. There still is controversy concerning interference with draining of the eustachian orifices and diminution of hearing. These points should be remembered and hearing tests as well as careful evaluation of the patient carried out periodically.

Dermabrasion Or Facial Sanding

Dermabrasion or facial sanding is a process of removing the epidermis and varying portions of the dermis usually with a rapidly revolving wire brush for the express purpose of planing the skin.^{30,31} It is a useful procedure for improving the appearance of skin that has been scarred by trauma, small-pox, chicken-pox, acne or other factors. It is used mainly in conditions where the skin has been scarred, but not totally destroyed. It is not useful over translucent "parchment thin" skin which has healed spontaneously over an area of tissue loss. Conversely it is not of much value in a hypertrophic scar or keloid.

Dermabrasion combined with scar excision is useful in the treatment of traumatic scars. The abrasive technique levels the skin while the concomitant scar excision narrows the scar.

In conditions where the lesions tend to be more superficial—uncomplicated lesions of small-pox—the more successful is the treatment. On the other hand, full thickness scarring of dermis with hypertrophic scar formation, as is seen in severe acne sequelae or lacerations in children, yield lesser benefits.

Skin types tend to show varying degrees of improvement. A soft, yielding skin which can be abraded to a fuzzy "cow's-tongue" consistency will yield better results than a tough, "sclerotic" skin which resists the abrasive wheel.

Untoward sequelae are: (1) Pigment formation in darker complexioned individuals during the healing phase. Some feel that this is photo-sensitivity brought on by too

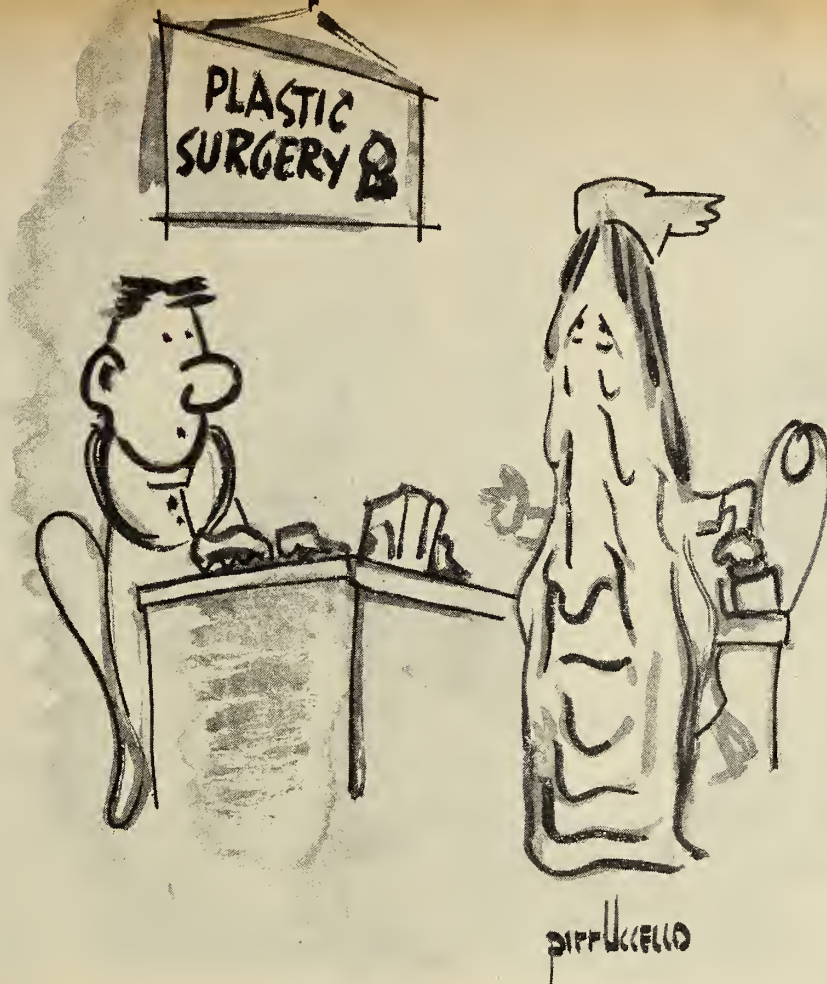


Fig. 7. "When did you first notice this condition"?

early exposure to sunlight. (2) Miliae formation can occur as early as two to three weeks. It occurs later in some cases. (3) Hypertrophic scarring in some areas that are deeper in involvement. (4) Infection is possible, but is unusual.

It has been our policy to do small patch areas of test-sanding in darker skinned patients. If this proves to be satisfactory after observing the area for from four to six weeks, then a total sanding can be carried out. New skin protective solutions on the market, such as Sol Bar® shows promise in the post-operative phase as they tend to screen out harmful rays. Miliae are usually self-limiting and are simply nicked with a #11 blade without anesthesia during the course of an office call.

The technique involves local or general anesthesia depending on the extent of the area involved. The skin is carefully washed with soap and water and draped. A rotating wire brush is used to abrade the skin over the desired area. There is a residual erythema which persists for a period of

weeks, sometimes longer, which resembles a healing sunburn or a second degree burn.

Dermabrasion can be done repeatedly in many cases where the depth of the scars demand it and the benefits accrued warrant it. This becomes a joint decision of the physician and the patient.

Dermabrasion is sometimes combined with face-lifting procedure to help minimize scarring around the mouth or cheek areas where the skin is furrowed with linear wrinkles.

Chemical Face Peeling

Chemical face peeling is a process by which the epidermis and the dermis, in varying thicknesses, are removed by chemical agents applied to the face.³²

The solutions, usually a mixture of phenol, water, croton oil and liquid soap, are applied to the face with cotton-tip applicators following which adhesive tape is applied to the facial skin under slight tension—care being taken not to crease the skin. The patient is sedated and placed

on a liquid diet. Approximately 48 hours later, the tape is removed.

Indications and counter-indications are similar to those advocated for facial dermabrasion. This is a useful procedure when done by qualified people.

Rhytidoplasty

Rhytidoplasty is an operative procedure devised for the aging face. Incisions are made bilaterally in the scalp and pre and post-auricular areas. The skin is extensively undermined through the face and neck, re-attached posteriorly and superiorly and the redundant tissue excised. In carefully selected individuals of stable temperament, the results can be most gratifying. (Fig. 7) Excessive demands by the patient, combined with a minimal deformity is a disastrous combination. Careful discussion with realistic aims, combined with real deformity leads to success. The patient is informed that the complete operation is approximately a three-hour procedure. The healing process is usually uneventful, though it can be complicated by seroma or hematoma.

Although the scars are relegated to inconspicuous places hidden by the hair, and placed along natural skin lines, the patient is always advised that scars will be present and that they are a normal part of the healing process.

Rhytidoplasty will improve and modify the worst of facial relaxation, but will not remove all relaxation or modify all wrinkles. To attempt this would be futile, as it would create dangerous tension on the skin and blood supply. Even if one were successful, the result would be an unnatural or "mask-like" face.

Unsightly eyelids with redundant tissue and herniating supraorbital and infraorbital fat pads can be improved considerably by a separate procedure.

Otoplasty

Protuberant ears can be corrected by a retroauricular incision through which sufficient skin and cartilage is excised to reshape and re-position the ears. It is a fairly well standardized procedure which has produced excellent results. It is carried out at approximately five years of age in most cases, especially in youngsters in whom psychological problems may be precipitated by the deformity.

Total reconstruction of the congenitally absent ear is a gratifying series of operations. The results in the past five to ten years are markedly superior to any previously obtained. The crumpled, malformed cartilage is removed and a local flap transposed to divide the vestigial tag at the first procedure. Following this, autogenous cartilage is removed from the 7-8th ribs anteriorly and carefully carved into a framework simulating the cartilage of the normal ear. This is placed in a subcutaneous pocket in the region of the absent ear. In a few months, this is lifted as a hinge, retaining its superficial attachment to the skin and its blood supply anteriorly. A split thickness skin graft is placed in the defect. Other refinement procedures are carried out at varying intervals. The result is not perfect, but it is reasonably good.

Corrective Rhinoplasty

Corrective rhinoplasty can be a gratifying operation, provided that the procedure is carried out to correct real deformity and that there is good communication and rapport between surgeon and patient (Figs. 8,9). Realistic aims in a stable patient with marked disfigurement is the ideal situation. Variations on this theme requires, of course, individual consideration. Secondary procedures to correct minor faults, and occasional post-operative bleeding are the most frequent complications.

Silicones

Silicones are chemical compounds which are composed of long chains of polymers of alternating silicone and oxygen atoms. When the chains are short, the silicone has a low viscosity fluid and when the chains are long, the fluid has a correspondingly high viscosity. Silicone "medical grade" products have, according to recent reports, appeared to be promising as transplant material.^{33,34} Numerous reports and studies are in progress to determine whether silicone is an acceptable implant material. Silicone fluid has been employed for medical usage as injectable subcutaneous and cutaneous prostheses. Some researchers have found that it is well tolerated in the subcutaneous tissues, evoking little inflammatory response. Systemic toxicity was not evident. Several questions remain to be solved, the most important being whether absorption of appreciable amounts occurs. The

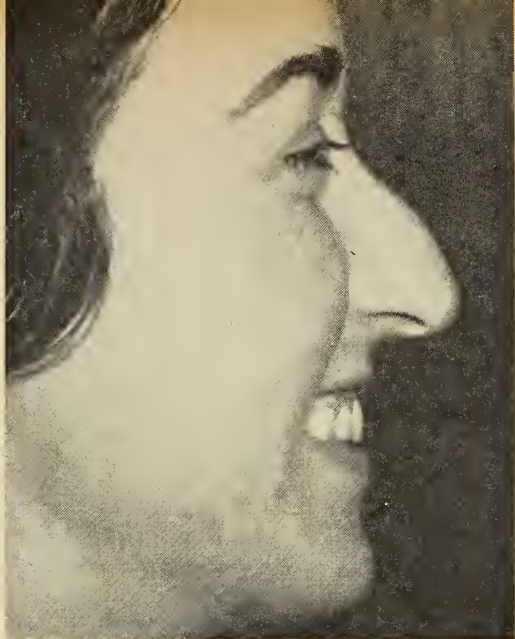


Fig. 8. Candidate for corrective rhinoplasty.



Fig. 9. Post-operative view of patient following corrective rhinoplasty.

final distribution of the silicone material is not known and if it is dispersed, what is its method of excretion?

A tumor mass has been observed in one out of 60 mice injected with silicone material. Wandering macrophages ingested the silicone and clustered together to form a tumor mass.³⁵ The possibility of more profound change must be investigated further. A test of time and extensive reporting by competent researchers will provide further illumination on the use of silicones. At present, injectable "medical grade" silicones are not on the open market, but are being used in selected research centers. Currently there is a moratorium on its general use.

Miscellaneous

Sensation in the anesthetic digit is being restored by using a neuro-vascular island flap.³⁶ The neurovascular island flap is also being used on the lower extremity in the treatment of ulcers in anesthetic weight-bearing surfaces.³⁷

Pseudomonas aeruginosa is apparently capable of converting an experimental second degree burn to a third degree burn by occluding dermal circulation. This can be treated by using topical and systemic gentamicin sulfate.³⁸

Depletion of vitamin C level in burns is often overlooked. An adult may require 500 to 1000 mg. of vitamin C daily to compensate for this loss.³⁹

The use of 0.5 percent solution of silver nitrate in the treatment of burns shows great promise.⁴⁰

The answer to permanent homografting probably lies in the typing of tissue and in antigenic infusion. At the present time most experimental work continues to be directed toward generalized immuno-suppression.⁴¹

Summary

An effort has been made to review pertinent facts in the history and development of Plastic and Reconstructive Surgery. Current concepts in the management of patients have been presented.

I would like to thank Dr. Martin R. Sullivan for his help in the final preparation of this manuscript.

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Disorders of Ocular Motility

By EUGENE R. FOLK, M.D.

Disorders of ocular motility are extremely common. Estimates range from two to five percent of the general population. As a result, the literature dealing with this subject is quite voluminous. In this review I have attempted to present those trends which have been most significant during the past 10 years.

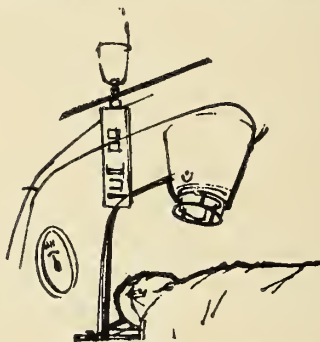
These disorders are generally divided into two groups, paretic and non paretic deviations. A paretic deviation is similar to a lower motor neuron lesion indicating some disease process involving the third, fourth, or sixth nerves, or their nuclei, with a paresis or paralysis of the muscles supplied by these nerves. A non paretic deviation or comitant strabismus might be compared to an upper motor neuron lesion and represents a disorder of higher centers. There is no muscle weakness but a symmetrical inward (esotropia) or outward (exotropia) deviation of the eyes.

Causes of Paretic Deviations

Rucker^{1,2} has presented two excellent studies of the causes of paretic deviations. Involvement of the sixth cranial nerve was by far the most common, accounting for almost three quarters of the total patients studied. The most common cause of a sixth nerve palsy was an intracranial neoplasm. Other frequent causes in this group were head trauma, vascular disease, and inflammatory diseases of the central nervous system. Fourth nerve palsies were usually due to head trauma and vascular disease. It was interesting that in none of his cases was there an isolated fourth nerve palsy due to an intracranial aneurysm. On the other hand, intracranial aneurysm was one of the more prominent causes of third nerve palsy. Equally common as a cause of third nerve disease were vascular disease, neoplasm, and head trauma. The pupil was most commonly affected when the patient suffered from a proven aneurysm. In this series from

the Mayo Clinic, only one case of ocular motor paresis due to syphilis was encountered. The sixth nerve was the most common nerve affected by inflammatory processes such as meningitis, encephalitis, and multiple sclerosis. Green and his co-workers³ found a smaller incidence of neoplasm in their group of third nerve palsies. They found that most of their vascular causes were related to diabetes. The findings of these two groups are not too different from those in our local clinics.⁴ I might also add myasthenia gravis as a rather common cause of isolated palsies of the extraocular muscles.

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Non Paretic Strabismus

The etiology of non paretic strabismus is not fully understood at this time. There are two basic theories accounting for this type of deviation. The first considers all deviations of this type to represent a disorder of higher centers, more specifically those dealing with convergence and divergence. An esotropia is therefore caused by

excessive convergence or deficient divergence innervation. Similarly, exotropia is a result of excessive divergence or deficient convergence stimuli. The second theory feels that comitant deviations are due to abnormal muscular and fascial attachments. A necessary component to the innervational theory was the existence of centers for convergence and divergence. The center for convergence is universally admitted, and it is assumed to be situated in Perlia's nucleus. However, a center for divergence has not been isolated and the mechanical school has always considered divergence a passive process as a result of the contraction of stretched tissues.

Ocular Electromyography

Breinen,^{5,6} Miller,⁷ Jampolsky,⁸ Tamler,⁹ and Marg investigated the nature of divergence by the use of ocular electromyography. Small bipolar needle electrodes were placed in the extraocular muscles, using only topical anesthesia so as not to interfere with muscle function. These were connected to an oscilloscope and changes in amplitude and frequency of the electrical potential were observed during various eye movements. Escape from convergence, as an object was brought toward the nose, was found to involve an active firing in the lateral rectus muscle. Similarly, the outward movement of the eye in intermittent exotropia was associated with increased frequency and amplitude of electrical activity from the lateral rectus. Hence, divergence was proved to be an active process, even though the location of the center could not be demonstrated. The increased firing in the medial rectus during convergence was also demonstrated. Similarly, the increased deviation which is characteristic of accommodative esotropia when the patient's glasses are removed, was also demonstrated to be on an innervational basis.

Blowout Fracture of Orbit

The electromyographers were also able to confirm the basic laws of Sherrington. The innervation to the antagonist muscle was demonstrated to decrease as that to the agonist increased. This can only be demonstrated with the extraocular muscles which have a constant tonic innervation, whereas skeletal muscle seems to be electrically silent. Breinen¹⁰ has summarized the whole subject of ocular electromyography.

Smith, Converse, and Regan^{11,12,13} described and explained the mechanism of the so called blowout fracture of the orbit. A blunt injury to the eye causes the intra-orbital pressure to increase suddenly. The thin floor of the orbit gives way with prolapse of the orbital contents into the maxillary sinus. The inferior rectus muscle is usually caught in the fracture causing a paresis of that muscle. If it is firmly held, as is frequently the case, limitation of upward gaze in the abducted position suggests that the superior rectus is also paretic. If the prolapse is extensive the patient is also enophthalmic and frequently has anesthesia of the area supplied by the infraorbital nerve. Soll and Poley¹⁴ demonstrated that it is possible for the inferior rectus to be entrapped in a small fracture without any displacement of the orbital contents. Frequently, the initial injury may seem to be a minor one, but the presence of diplopia following this type of injury should arouse the suspicion of the examiner. The treatment consists of elevating and freeing the orbital contents and correcting the defect with a bone graft or suitable inert plastic material.

Paresis With Thyroid Disease

The paresis of upward gaze associated with thyroid disease is well known. Miller¹⁵ has identified abnormal adhesions between the inferior rectus and the inferior oblique in a number of patients with this condition. Severing these adhesions and recessing the inferior rectus resulted in restoration of normal elevating ability. Long¹⁶ feels that the primary problem is a contracture of the inferior rectus muscle and also advocates recession of the inferior rectus. Most important is the fact that tropias of thyroid origin can be corrected by surgical intervention.

A new mechanism to explain the Stilling-Turk-Duane syndrome was presented. In this fairly common syndrome there is usually a limitation of abduction and retraction of the globe on attempted adduction. Employing electromyography, Blodi¹⁷ and his co-workers discovered an abnormally innervated lateral rectus in this condition.

Once a patient has developed a deviation, objects in space fall on non corresponding retinal elements, and he is aware of diplopia. The same object is seen in two places. The most common adaptation to this

problem is to suppress one of the images. Habitual suppression of the image in one eye leads to amblyopia, or defective vision in an otherwise normal eye which cannot be improved with glasses. In many instances, when asked to fix with the amblyopic eye, the patient will look at the object of regard with an extrafoveal area. When this occurs, the patient is said to have eccentric fixation. Much of the current literature dealing with strabismus describes the treatment of amblyopia and eccentric fixation.

Treatment of Eccentric Fixation

For some time it was felt that patients with eccentric fixation did not respond to conventional occlusion techniques. To treat this condition more effectively Cüppers¹⁸ in Germany and Bangerter¹⁹ in Switzerland devised an elaborate system which they called pleoptics. Eccentric fixation is best diagnosed by the use of the visuscope designed by Cüppers. This is a modified ophthalmoscope which enables the examiner to project a fixation target on the retina. Pleoptic treatment begins with occlusion of the eccentric eye for a period of one to two months. This is known as inverse occlusion. The parafoveal areas of the eccentric eye are then dazzled with a bright light while the foveal and macular regions are shielded. To accomplish this, Cüppers uses his euthyscope and Bangerter his pleotophore. The patient is then encouraged to fix with the shielded area in order to re-establish foveal fixation. The pleotophore also has a weak stimulating light. Pleoptics is a very long and time consuming type of treatment, generally requiring hospitalization of the patient for a period of four to six weeks. Krzysthawa and Pakajawa²⁰ and Speiser and Witmer²¹ compared the results utilizing the techniques of Cüppers and Bangerter and found no difference between them. Because of the time involved only a limited amount of pleoptic training has been done in this country. Von Noorden and Lipsius²² found the results of pleoptics disappointing. More recently, efforts were directed to early intensive occlusion. That is constant patching of the non amblyopic eye for periods of six months or more in children below the age of four years. Scully,²³ von Noorden,²⁴ Parks and Friendly,²⁵ and Mackensen, Kroner, and Postic²⁶ all presented enthusiastic reports using this technique.

At the present time there can be no question that the treatment of choice of amblyopia, with or without eccentric fixation, in children under the age of four, is constant patching of the fixing eye. Pleoptics may be of value in the treatment of eccentric fixation in older children. Since the cure rate of amblyopia is higher with occlusion therapy, it is the obligation of every physician to see that children with strabismus are seen and treated as soon as the diagnosis is made.

A and V Syndrome

Conventionally evaluation of an ocular deviation required measurement of the deviation for distant and near fixation with and without glasses and a study of the ocular rotations in the so called six cardinal directions. That is, up and right, down and right, straight right, straight left, up and left and down and left. In a series of articles, Urist^{27,28,29}, called attention to the straight up and straight down positions. He found that 70 to 80 percent of all non parietic deviations fell into four groups. These groups have been popularly designated the A and V syndrome. A "V" esotropia is an esotropia which is greater looking down than up, greater for near than for distance, with bilateral elevation in adduction. That is on lateral gaze, the adducting eye shoots up. A "V" exotropia is an exotropia which is greater looking up than down, greater for distance than near, with bilateral elevation in adduction. An "A" esotropia is an esotropia which is greater looking up than down, greater for distance than near, with bilateral depression in adduction. An "A" exotropia is an exotropia which is greater looking down than up, greater for near than distance, with bilateral depression in adduction. Urist uses the straight up and down positions as a guide to determine which horizontal muscles should be operated to correct the deviation. "V" esotropias do better with surgery on the medial rectus muscles, and "V" exotropias do better with surgery on the lateral rectus muscles. "A" deviations require surgery on a lateral rectus and a medial rectus in the same eye.

Whereas, the "A" and "V" syndrome is universally accepted and its importance recognized, the treatment varies considerably. Hugonnier³⁰ advocates surgery on the vertical muscles. Miller³¹ would laterally displace the vertical rectus muscles.

Cüppers³² would tuck the oblique muscles. Fink³³ would tuck the superior oblique in "V" patients and tenotomize the superior oblique in "A" patients. Jampolsky³⁴ would tenotomize the superior oblique in "A" patients and recess the inferior oblique in "V" patients. Knapp³⁵ advocates vertical displacement of the horizontal muscles as well as recessing or resecting these muscles. This variety of treatment is equally perplexing to the ophthalmologist and the non ophthalmologists. I strongly support⁴ Urist's position and feel the other procedures are more dangerous and less predictable.

Proper Age for Surgery

Most ophthalmologists would agree that all ocular deviations should be corrected before a child starts school. However, there is some disagreement about the proper age for surgery. It is an attractive thesis that the earlier eyes are straightened, the better the chances of restoring normal function. For this reason Costenbader and Albert³⁶ and Taylor³⁷ have advocated surgery as early as six months of age for congenital esotropia. They feel the anesthetic risk is no greater and they can properly evaluate a child by this age. Arruga³⁸ feels the results are better when surgery is postponed until the age of two or three and that the anesthetic morbidity is less. Ing, Costenbader, Parks, and Albert³⁹ in a study of children who had surgery between the ages of six and eighteen months of age found that it was possible to achieve a type of peripheral fusion, but none of their patients achieved foveal fusion. Fletcher and Silverman^{40,41} were unable to demonstrate any greater percentage of "functional" cures with surgery before the age of eighteen months. They found that reoperation for undercorrection and overcorrection is required more frequently when surgery is performed before the age of eighteen months. My own experience coincides with that of Fletcher and Silverman and I believe that the best age for surgery in congenital deviations is between the age of two and three.

These are the major subjects which have appeared in the ophthalmic literature dealing with ocular motility in the past ten years. I have deliberately avoided any discussion of specific surgical techniques.

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Lipid Metabolism In Brain Injury

By ALBERT R. ROSANOVA, M.D., REX AMBERSON, M.D., MICHAEL WHITE, M.D.
AND MARIO PRIOLETTI, M.D.

Surprisingly little attention has been paid to lipids and their alterations in brain injury. This fact becomes even more astonishing when we realize that approximately 55 percent of the dried brain¹ is made up of lipids and, if we confine ourselves to the white matter, approximately 65 percent of the dried, white matter² is made up of lipids. Therefore, it becomes obvious that it is important to investigate what happens to the lipids of the brain as a result of trauma.

The importance of such a type of investigation is obvious since there are 2,300,000 persons in the United States who suffer head injuries in auto accidents alone each year.³ This does not count the thousands who suffer injuries to the head because of falls at home and other accidents including cerebro-vascular accidents, or the thousands of newborn infants whose brains are injured during an absolutely normal⁴ delivery and even in ideal deliveries carried out by cesarean section.⁵

Thus, we can see that birth itself is a hazardous process. Because of the tremendous molding and shaping that takes place in the newborn's head on its passage through the normal birth canal plus the changes from hydrostatic to atmospheric pressure during birth, it is a wonder that any one of us has escaped brain injury during our own birth.

Philip Schwartz,⁶ Director of the Department of Pathology at Warren State Hospital, Warren, Pa., has shown that gross intracerebral extravasations of blood and softening processes occurred in approximately 65 percent of newborn children who died at delivery or during the four weeks immediately after birth. These observations have

been confirmed by Claireaux,⁷ Walsh and Lindenberg,⁸ and Banker and Larroche.⁹

Methods

Our study has been going on for the last three years. We have studied altogether the brains of 20 dogs. The dogs were about seven to eight weeks of age when our studies began. Four of the animals were used as controls. The remaining 16 were all brain damaged according to the "Pendulum-weight" method of Denny-Brown.¹⁰

Our first step was to sacrifice the four control animals. They were put to sleep with intraperitoneal sodium secobarbital, using approximately one grain per five lbs. of body weight. We found that our puppies would be completely asleep within two to three minutes with this method. The entire brain was then removed from all four of these animals using a sterile, lipid free technic. In order to get all of our instruments, etc., lipid free, everything was thoroughly washed repeatedly in distilled ether and then allowed to completely dry.

We now took a sample from the right parietal lobe on each of these four puppies. Our sample was a fairly large sized, wedge-shaped piece from the right parietal area which included the cortex but not the underlying white matter. The samples were immediately homogenized, weighed, and then thoroughly mixed with anhydrous acetone using about three times as much acetone in volume as the volume-mass of the brain tissue sample. This was then allowed to stand (in a tightly closed container) at room temperature for two days. The mixture was then dried at room temperature. The residue was weighed and then thoroughly mixed in a 2:1 chloroform-methanol solution which was 10 times the weight of the residue; and then mechanically agi-

From the Foundation for the Study of Mental Retardation Northwest Hospital, Chicago

tated. After 24 hours, samples were taken from the liquid for chromatographic, thin-layer analysis.

Thin-Layer Chromatography

We used a thin-layer chromatography technic as described originally by Egon Stahl¹¹ in his well known laboratory handbook on thin-layer chromatography. Our plates were made up of Silica-Gel G according to Stahl, and coated about 300 microns thick for our qualitative work and about 500 microns thick for our quantitative work. These were allowed to dry overnight and then activated by heating in an oven at about 120° C. for one hour. The plates were removed from the oven and while they were still tepid, they were spotted with a micropipette at a level about 1.5 cm above where the solvent would reach when the plate was placed into the developing tank. For our quantitative work a special microsyringe or micro-meter pipette was used because this delivers a definite, known amount of specimen each time.

The solvent used by us for development of the plates was: Chloroform-methanol-water in a 70:30:5 ratio. This was first placed into the developing tanks so that the atmosphere in the tank would become

saturated with the solvent. Then the spotted plates were placed into the tanks. The usual time that was needed for the development of the plates was about 40 minutes.

The plates were then removed from the solvent tanks and allowed to dry. They were then placed into tanks which contained iodine vapors. These vapors were obtained by putting a few crystals of iodine in the bottom of the tank and letting it stand for a while. All of the spots which had lipids on them showed up beautifully with the iodine vapors. We tried different types of sprays with iodine and with other dyes and detection reagents which were supposed to make the lipid spots visible; but no matter which one we tried, we always came back to our iodine as this seemed to give us the best visualization of our lipids.

Iodine Colored Lipids

Futhermore, the iodine is only bound physically to the lipids because when the iodine vapor treated plates are left exposed to the air, the iodine soon vaporizes and the lipids are no longer visible. However, if we put the plates back into the iodine vapor tanks, then the color on the lipids would return again. The iodine colored lipids are also good for quantitative analy-

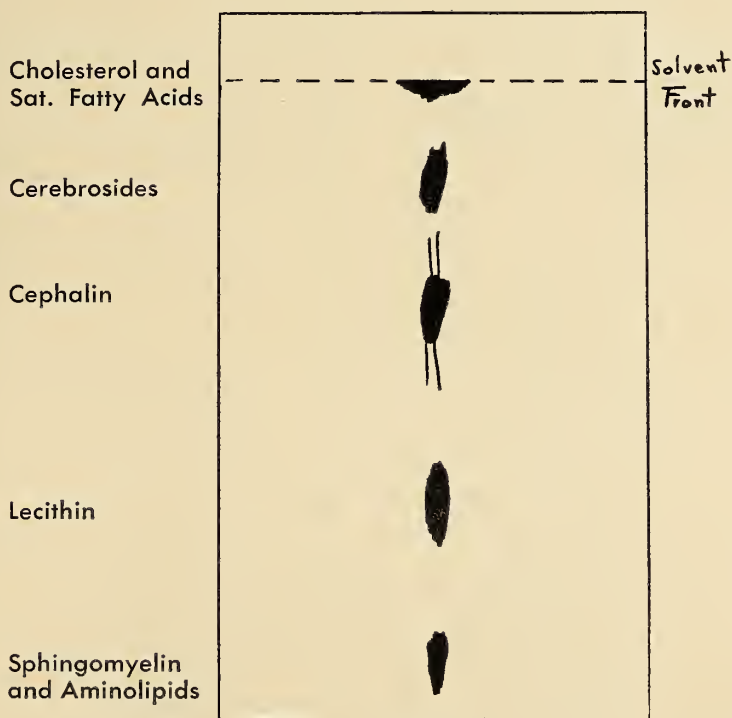


Fig. 1

sis with a densitometer. This gives us a rapid and accurate method for quantitative analysis of these lipids.

If one does not wish to use a densitometer, the individual lipids on the plates can be cut out and put into the proper containers. Then the lipid can be eluted out with a suitable solvent from the Silica-Gel G. Now the lipid can be determined photometrically or by individual chemical means if so desired. Therefore, we can see that the exact identification of each and every one of these lipids is possible and easily done.

Still another method used by us was to take the individual, pure lipids such as cholesterol, lecithin, etc., purchased from Sigma Chemical Co. or Nutritional Biochemical Co. or Mann Biochemical Co. and spot these individually on the plates. This gave us known standards for comparison on our own plates and technics.

Fig. 1 is an iodine-vapor, stained slide of normal dog brain lipids of the right parietal area.

The remaining parts of the brains of the four normal dogs were also immediately homogenized, and thoroughly mixed in acetone and let stand for 48 hours. Then the acetone was allowed to evaporate at room temperature. The residue was thoroughly mixed with a solution 10 times the weight of the residue. This solution consisted of chloroform-methanol in a 2:1 ratio. This was vigorously agitated mechanically for 24 hours. Then the solution was removed from the residue.

The solution was allowed to evaporate and the residue was weighed and then suspended with sterile water in which 100 mcgm of vitamin B₁₂, 100 mcgm of niacin, 100 mcgm of testosterone propionate and 100 mcgm of d alpha tocopherol were already suspended. This mixture was then placed in the refrigerator and was ready for use. Table #1 gives an analysis of each cc of this mixture.

The reason why the vitamin-testosterone suspension was used as a vehicle was because all four of the substances in it have been demonstrated in the past to have some connection with biosynthesis in nerve tissues either in vivo or in vitro. For example, the anabolic effects of testosterone are well known.⁹ Niacins rapidly cure the myelin degradation found in pellagra.¹⁰ Vitamin B₁₂ or cyanocobalamin deficient rats have been shown to have low lipid content in the carcass due to a decrease in lipid synthesis caused by the cyanocobalamin deficiency.¹¹ The anti-oxidant or preservative effects of the tocopherols on lipids is well known.¹²

Furthermore, it is realized that in a test tube we can isolate a single chemical reaction and carry on, but in the body all factors work together. Therefore, we cannot neglect other methods of treatment such as surgical intervention in subdural hematomae and other hemorrhages produced by the trauma, if needed; and reduction of the cerebral edema, treatment of shock, supplying of oxygen immediately to the brain tissues, etc. etc.

Now, we shall go on to see what happened to our remaining 16 dogs. As previ-

TABLE #1

Cephalins	80 mcgms
Phosphatidylethanolamine	
Phosphatidylserine	
Diphosphoinositide	
Lecithins	70 mcgms
Phosphatidylcholine	
Plasmalogens	30 mcgms
Plasmalogen choline	
Plasmalogen ethanolamine	
Plasmalogen serine	
Sphingomyelins	20 mcgms
Sphingosilphosphorocholine	
Phosphatidic acids	5 mcgms
Diglyceride phosphoric acid	
Cyanocobalamin	100 mcgms
Niacin	100 mcgms
Testosterone Propionate	100 mcgms
D Alpha Tocopherol	100 mcgms

ously mentioned, all of these were anesthetized and brain injury was produced by the pendulum weight methods so well described in the literature by D. Denny-Brown¹³ of Oxford University about 25 years ago.

Autopsies on Four Dogs

Four of our dogs never recovered from the trauma. Autopsies were done on these dogs. Dog No. 1 had a compression fracture of the right parietal area with an extradural and a subdural hematoma and lacerations of the dura with multiple petechial hemorrhages throughout different areas of the brain. Dog No. 2 had a comminuted fracture of the right parietal area with a subdural hematoma and multiple diffuse petechial hemorrhages throughout the rest of the brain areas. Dog No. 3 had a respiratory failure (immediately following the trauma) of four minutes followed by a cardiac arrest and expired in spite of artificial respiration and external cardiac massage. Autopsy failed to reveal any lesions in the right parietal bone or in any area of the brain substance itself both grossly and microscopically. Dog No. 4 died after three minutes of cardiac arrest immediately following the trauma. All resuscitation efforts failed. Autopsy revealed no gross nor

microscopic hemorrhages in any areas of the brain.

Phospholipid Treatment of Six

Of the remaining 12 dogs, six of them were not treated with the phospholipid mixtures and became our controls. The remaining six dogs were treated with 2cc intramuscularly daily for a period of two weeks of the mixture of the phospholipids as given in Table I. All dogs (both the treated and the untreated) were sacrificed after two weeks and the right parietal area of the cortex was immediately subjected to the same type of homogenization and thorough mixing with acetone for two days with subsequent drying out of the acetone and mixing of the residue with a 2:1 chloroform-methanol solution and mechanically shaken for 24 hours before taking a sample for our thin-layer chromatographic analyses.

Our thin-layer chromatographic analyses were carried out exactly as before described on Silica-Gel G using the 70:30:5 chloroform-methanol-water solvent for 40 minutes, drying, and then detecting the spots with iodine vapor as previously described. Fig. 2 shows our results in the damaged, untreated animals.

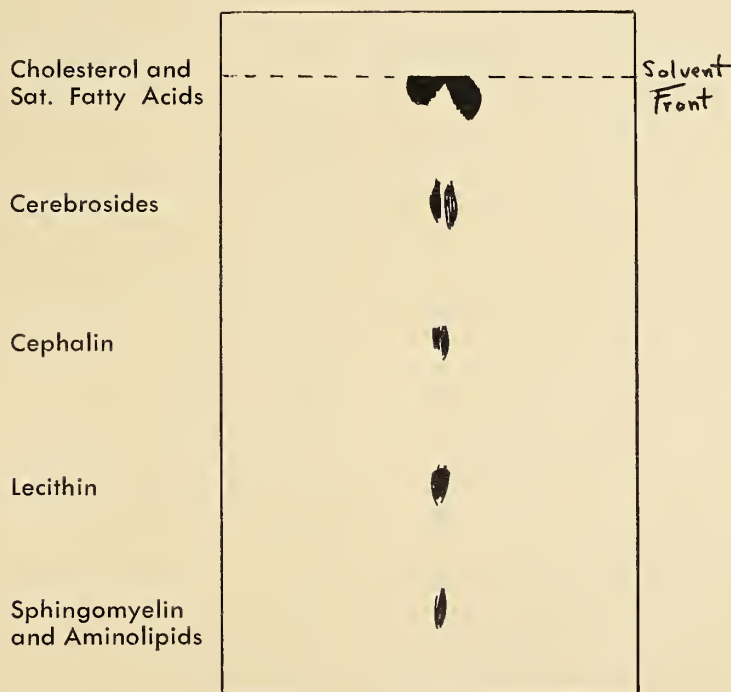


Fig. II

From Fig. 2 it is obvious that in the injured brain the amount of phospholipids is decreased and the amount of cholesterol and fatty acids is increased. Confirmation of this qualitative assumption was done both by densitometric methods and by determination of the total phosphates on the different spots separated out by the thin-layer chromatograph.

The right parietal cortex in our control animals had approximately 12½ to 13 micrograms of phosphorus per milligram of dried residue. The traumatized right parietal cortical area measured about 9 to 10 micrograms; and 11 to 12 micrograms for the traumatized parietal cortex in the treated dogs. This confirmed our qualitative assumptions.

Fig. 3 shows our results on the thin-layer chromatography of the right parietal cortical areas in the treated dogs.

Discussion of Results

By qualitative and quantitative thin-layer chromatography methods we have shown that there are biochemical differences in the simple and complex lipids in the right parietal cortical area of the normal brain, the traumatized parietal cortical area brain, and the treated traumatized parietal

cortical area brain. Out of curiosity we did examine other areas of the brain such as the left parietal, both occipital lobes and both frontal lobes of the normal, traumatized and non-treated, and the traumatized but treated animals and we did find that the same qualitative changes were produced in other areas of the brain as in the direct area of trauma although quantitatively these changes varied from one area of the brain to the other.

Based on our observations we can also state that in general in the brains of the traumatized, untreated dogs there was an increase of the fatty acids and of the cholesterol and a decrease in the phospholipids particularly in the phosphatidic acids and in the cephalins. In our phospholipid treated dogs the phospholipids, cholesterol, and fatty acids tended to come back towards the normal.

At this point we wish to issue a warning and that is that our work was done on dogs and therefore does not necessarily apply to humans. However, from the very nature of this work I am sure that no one will ever do this type of experimentation on humans. Therefore, we may have to take some of these animal results and transfer them to human use if they are to be of any value

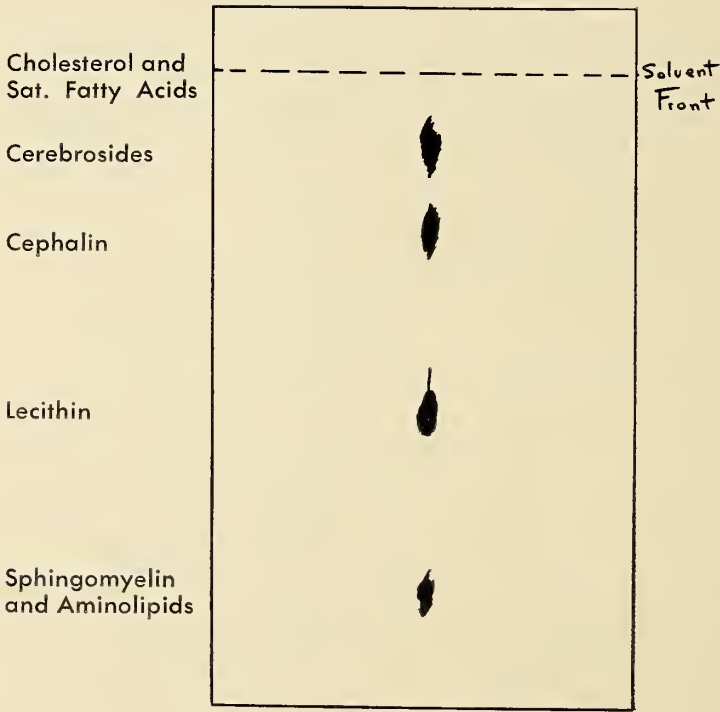


Fig. III

to us whatsoever. If we do this, we must use caution and above all realize that treatment was started a short time after the trauma was incurred. This would mean that administration of the proper phospholipids and their precursors immediately after the birth of all babies or after any head injury might prevent the appearance of full blown symptoms of brain damage and mental retardation years later. The behavioral syndrome of a brain damaged child and adult includes such components as hyperactivity, distractability, emotional lability and inconsistency.¹⁴

Our untreated dogs did act remarkably like the brain damaged child. When we walked into the room where they were kept, we could tell immediately which were the brain damaged dogs because these dogs jumped to their feet, started barking and howling, and walked from one end of their cage to the other continuously while we were in the room. We tried to pet these dogs while feeding them and we could never trust them; because we never knew when they would turn around and bite the hand that fed them. It is true that we did no I.Q. tests on these dogs as we were interested only from a biochemical standpoint. The I.Q. on brain damaged dogs we leave for someone else to investigate.

However, we did notice that our treated

dogs gradually calmed down and, were less hyperactive, and could be petted without fear of recriminations.

Summary

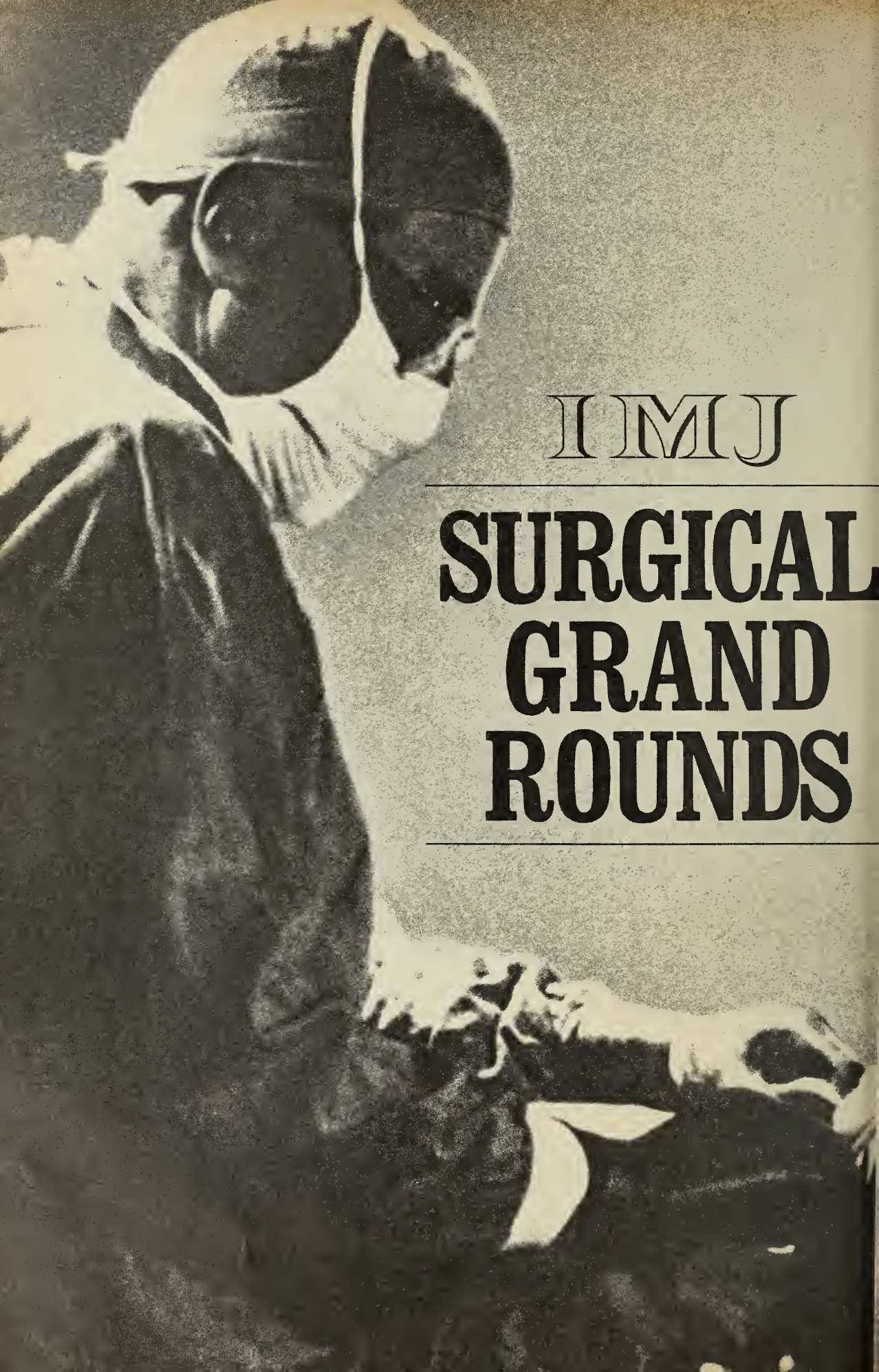
In closing we wish to state that because of our work and the work of others with radioactive labelled lipids, the old notion that the brain is composed entirely of fixed, unchanging tissues must be dispelled.¹⁵ Instead we must realize that the brain tissues are more like department stores during the Christmas rush hours. They seethe with biochemical activity, decomposition and synthesis neatly balancing each other and forever ready to change especially in the presence of physical or chemical trauma. It is therefore up to us to see that this change in the ceaseless round of metabolism is protected from physical or chemical trauma, and when it is too late for us to protect, then we should as soon as possible stop all further trauma and supply the needed precursors in the links of the molecular chains. Our work shows that the brain itself is no longer to be looked upon as unchanging, unwielding, and unchallengeable.

Acknowledgment

The authors are indebted to Michael Hanuschewsky for his assistance in preparing the Silica-Gel G plates and his many valuable technical contributions.

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II MJJ

**SURGICAL
GRAND
ROUNDS**

Lymphosarcoma of the Mediastinum

EDITED BY JOHN M. BEAL, M.D.

Northwestern University Medical Center

Surgical Grand Rounds are held weekly at 8 a.m.; alternating between the Staff Room, Chicago Wesley Memorial Hospital and Offield Auditorium, Passavant Memorial Hospital. Patient presentation from these hospitals and from the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of Surgical Grand Rounds held at Passavant Memorial Hospital on Jan. 14, 1967.

Dr. William Nowlin: The patient, a 34-year-old Negro male, was admitted to the Veterans Administration Research Hospital, Nov. 21, 1966, because a shadow had been discovered in the right lung field on a routine mobile chest x-ray. Otherwise the patient had been asymptomatic and denied weight loss. Past history and systemic review were essentially negative; the patient does not smoke. Physical examination: Blood pressure, 130/90; weight 238 pounds. The examination was unremarkable. Laboratory

findings included a normal hematocrit and a white blood cell count of 5,800. A chest roentgenogram was obtained after admission.

Dr. William Brand: A PA film of the chest (Fig. 1) showed a widening of the mediastinum, predominantly to the right. A superior vena cavogram and oblique chest films localized this mass to the middle mediastinum, probably adjacent to or arising from the region of the azygos node. Further, the ROA view of the chest suggested extension to the left of the mediastinum. There was no obstruction of the superior vena cava.

Dr. Joseph Sherrick: The specimen was an obviously enlarged lymph node. Microscopic examinations demonstrate that the capsule shows only slight or minimal infiltration by lymphocytes. There is considerable cellularity in the stroma of the node. There is uniformity of appearance of the cells and there are a few reticulum cells still present. Occasional follicles are preserved. The architecture is distorted but not completely destroyed. These findings are consistent with a diagnosis of a very well differentiated lymphosarcoma of the small cell type. (Fig. 2.)

PATIENT IS PRESENTED

Dr. Nowlin: The operation was performed through a right postero-lateral incision (demonstrates incision).

PATIENT LEAVES

Dr. Nowlin: A lymphangiogram was performed by Dr. John Scarff.

Dr. Brand: The films obtained 24 hours after lymphangiography show bilateral visualization of the inguinal, iliac and para-aortic nodes. Considering that this patient

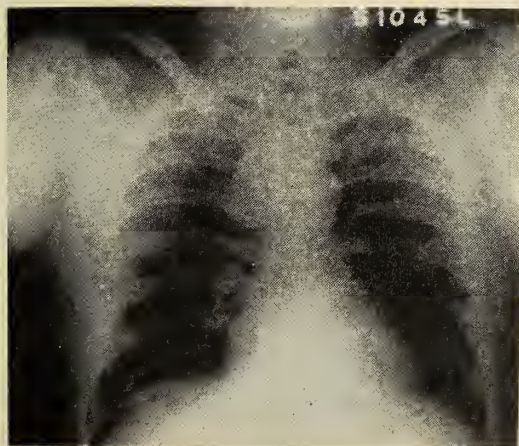


Fig. 1. Roentgenogram of the chest demonstrated a mass in the mediastinum.

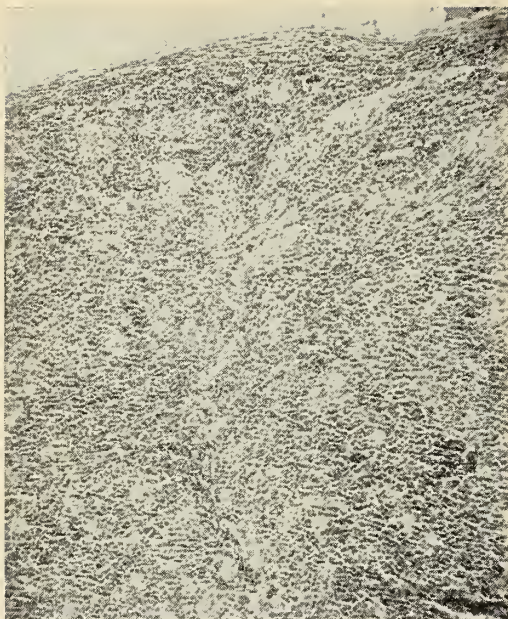


Fig. 2. Photomicrograph of mediastinal lymph node, which shows capsular infiltration and loss of usual architectural pattern. (X 120).

has lymphosarcoma, it is quite surprising to see few gross signs of involvement of the retroperitoneal nodes. However, this is an abnormal study (Fig. 3). In the report by Lee and associates,* 39 of 40 patients with apparently localized lymphosarcoma or reticulum cell sarcoma had occult involvement of the retroperitoneal lymph nodes demonstrated by lymphangiography.

Dr. John Beal: Dr. Shields, the diagnosis of lesions adjacent to the mediastinum is often difficult. Would you comment on the differential diagnosis in such problems?

Dr. Thomas Shields: When this patient was presented at the Chest Conference, the majority thought that unilateral mediastinal disease was present. It was not until the mass was exposed that the bilateral nature became apparent. The lymphangiograms were not obtained until after the thoracotomy was performed. The preoperative impression was that a middle mediastinal tumor was present. The most common lesions in this region include enterogenous cysts, lymphogenous cysts, and pleuropericardial cysts. My impression was that this

was a lymphogenous cyst. One internist suggested that this might be an aneurysm from the ascending portion of the arch and for this reason, an angiogram. was performed. However, in an asymptomatic young male without heart disease, this seemed unlikely. We considered lymphoma, but thought that the unilateral nature made a cyst more probable. When operation was performed it was immediately obvious that the mass was caused by lymph nodes arising from the mediastinum.

The main portion of the specimen was a single large node but there were multiple smaller nodes adjacent to it. There have been some recent reports of disease in the mediastinum of Hodgkin's origin in which the long term results have been improved, they think, by doing a thymectomy at the same time, so we performed a thymectomy along with the complete dissection of the superior-anterior mediastinum. The mediastinum was free of obvious involvement in the postoperative film. I would be interested in opinions concerning future management.

Dr. Walter Rambach: Dr. Shields spoke to me yesterday concerning the therapeutic approach to this patient. One has to assess the problem from the standpoint of the extent of involvement of the lymph nodes. As first presented, the patient would be classified as being a Stage I lymphosarcoma. He did not have constitutional symptoms and the involved lymph nodes were in a single, major area. Now that the diagnosis has been made surgically, irradiation of the mediastinum appears to be indicated.



Fig. 3. The lymphangiogram demonstrated abnormal nodes in the iliac group, which are compatible with a diagnosis of lymphosarcoma.

* Lee, B. J.; Nelson, J. H. and Schwarz, G.: Evaluation of Lymphangiography, Vena Cavagraphy, and Intravenous Pyelography in Clinical Staging of Hodgkin's Disease and Lymphosarcoma. New Eng. J. Med. 271: 327-337, 1964.

However, consideration must be given to the lymphangiographic studies which are suggestive of involvement of the pelvic nodes, and accordingly he might have to be classified as having Stage III disease. The lymphoangiogram becomes important in consideration of treatment. If the lymphangiogram does indeed demonstrate positive pelvic nodes, then one is anticipating Stage III disease in a patient without constitutional symptoms. If the lymphangiogram is negative then one considers the disease localized to one area and radiation therapy to the abdomen or pelvis or chemotherapy, would not be indicated. After review of these lymphangiograms, I think that they show findings associated with lymphosarcoma and that this patient should receive radiation therapy to the periaortic and pelvic chains as well as the mediastinal area. This case places appropriate emphasis on the value of lymphangiograms. If lymphangiography had not been available, we would have assumed that this man was in Stage I of the disease and that his disease was sharply localized. It has been estimated that 40 to 50 percent of patients formerly classified as having Stage I or II disease, are demonstrated to be in Stage III by lymphangiography. Thus, this technique is a major diagnostic tool in lymphomatous diseases. The question about differentiation of the tumor, will influence prognosis. Dr. Sherrick can report if the lymphoma is a well differentiated small cell tumor, whether it is predominately a lymphoblastic tissue or whether it is reticulum cell tissue. The prognosis is increasingly poor in that order. However, caution must be exercised in making the diagnosis on the basis of a single node.

Dr. Walter Carroll: Having in mind the long range view, what would your choice of chemotherapy be in the future, should it be indicated?

Dr. Rambach: Nitrogen mustard. As far as lymphomas are concerned, if we are not dealing with Hodgkin's disease, the drug of choice remains nitrogen mustard. Chlo-

rambucil or Cytosan are useful, and at times may be more effective if combined with Vinblastin. However, generally I believe that the first choice is nitrogen mustard. On the other hand, if the process is Hodgkin's disease, then I would use Velban (Vinblastin) at regular intervals of 3 to 6 weeks. This has the advantage of ease of intravenous administration on an outpatient basis, and has little if any of the nauseous side effects of nitrogen mustard.

Dr. Sherrick: The treatment for the patient with lymphoma is symptomatic and this patient does not have symptoms. Does this influence your therapeutic approach?

Dr. Rambach: I don't think that your statement is quite correct; that is, that we wait until the appearance of symptoms before treating. In this particular individual, assuming now that we have a positive lymphangiogram, there is little question as to the eventual development of symptomatology in terms of those particular nodes. Under appropriate therapy with a large enough radiation dose, it is quite conceivable to completely suppress these nodes, so that in the future they won't cause symptomatology. In that sense then I think they should be treated. It must be recognized however, that treatment now or later is of no particular moment in determining the individual's longevity, unless by earlier treatment we prevent some future complications.

Dr. Brand: By and large, it is possible in lymphosarcoma to differentiate between the appearance of lymphomatous node and that of hyperplasia or inflammation. On histologic examination the *Ethiodol* is seen in the reticulum cells which accounts for the characteristic x-ray appearance. A biopsy is needed to establish the diagnosis. In the patient presented today, the extent of his disease can be determined by lymphangiogram without additional biopsies. A lymph node involved by lymphoma demonstrates general enlargement with an increase in the space between the reticulum cells to give an appearance of "foaminess."

Traumatic Neuroses and Post Traumatic Syndromes

By H. H. GARNER, M.D./CHICAGO

The traumatic mental disorders have as their etiology injuries to and about the head. A distinction should be made between traumatic mental disorders which are an expression of symptoms related to head injury and the traumatic neuroses which may be considered as including neurotic expressions which result from or are precipitated by any threat to the physical integrity of the individual.

Traumatic mental disorders are more common among men, are especially apt to be seen in alcoholics, and are more likely to be seriously disabling in the older age groups and in children because of the increased vulnerability of the brain. The classification in current use is that of:

Brain disorders due to and associated with trauma. The following are the subdivisions of traumatic brain disorders:

Acute and subacute concussion syndrome, traumatic coma, traumatic delirium and the Korsakoff or amnesic confabulatory syndrome.

Chronic brain disorders associated with trauma include the following syndromes: associated with birth trauma; associated brain trauma; associated with brain operation; associated with electrical brain trauma and associated with irradiational brain trauma.

Syndrome Following Head Injury

Disturbed psychological balance in which traumatic neuroses, psychoneurosis and psychophysiological syndromes follow upon a head injury or injury to other parts of the body are more commonly seen in practice. The most common type of mental disorder seen after severe trauma is the post

traumatic neurosis. Traumatic neuroses may be described as disturbed, vacillating, disintegrated adaptations to traumatic stress which are not economically sound and which result from any type of physical injury to the organism, or may result from the anticipation of a physically mutilating or death threatening situation.

Psychopathology and Psychodynamics

The traumatic neuroses gives one an opportunity to see at first hand how homeostasis may be maintained or brought into disbalance by internal or external stress. The breakdown in homeostasis following injury varies with the extent to which the reserves for maintaining equilibrium prior to trauma are already being utilized to establish a steady state. Many factors contribute to the maintenance of the equilibrium or disequilibrium, among the most important of which are: ¹the defenses used for and bound in neurotic conflicts; ²the relationship of the new trauma ³to previous trauma, (summation effect); ³the strength of the forces which have maintained equilibrium, ⁴(constitutional and environmental); ⁴and the situation under which trauma occurs. Whenever an opportunity to protect oneself against the traumatic effects are available or escape is possible, some of the adaptational maneuvers concentrate attention on coping with the threat and in motor activity which enhances the forces for maintaining equilibrium. When action to avoid or cope with the danger is not possible, overwhelming anxiety and panic create a partial or total disorganization of mental functioning. The discriminatory faculties of the individual have the important role of evaluating the incoming stimuli which suggests the possibility of danger, the mobilization of the defenses of the organism and the evaluation of the nature, the degree, and the direction from which

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trauma may be expected. The incoming stimuli are sifted for their significance. Proper channels of discharge are sought or methods of limiting, fixing and binding the incoming impulses are utilized. Sometimes the excitations are too strong to be effectively managed by the inner regulating faculty of the organism-input overload. The failure of the higher center controls leads to the release of the inhibited older and less adequate methods for managing the threat.

Neurotic Conflict in War

The war neuroses were often activated by a neurotic conflict. The struggle between the aggressive impulses being mobilized by the permissiveness toward killing and mutilation and the previous training in restraint, control and the expectation of retribution for violation of the code against expression of aggressive impulses. The civilian traumatic neuroses are often characterized by the fact that defenses may have been developed in depth against the awareness of any anxiety over the threat of mutilation, (castration anxiety). The traumatic experience may therefore be a minor one but the reserves for adaptive functioning are minimal. The markedly dependent, over anxious person in the presence of physical dangers, (overprotective mother's son), is likely to develop a traumatic neurosis with relatively minor physical assaults. Where there has been a strong defensive pattern developed so as to counter the tendency of fear of physical assault, the occurrence of a physical injury, which was not expected may be enough to break the rigid defenses and unleash pent up anxiety. For instance, individuals may react to the fear of physical annihilation by counterphobic measures which result in considerable muscular development through weight lifting. On the appearance of an unusual or unexpected threat to physical integrity such an individual may develop a full blown traumatic neurosis. The symbolic meaning of the injury may be a most significant determinant for the development of a classical syndrome. The individual with a large emotional investment in his intellectual prowess may be exceedingly vulnerable to a head injury. By contrast a skilled craftsman may respond to the loss of an index finger with a typical acute traumatic neurosis. The injury may be interpreted as pun-

ishment for guilt, the threat of loss of parental love, or as a direct attack upon the person, symbolically experienced as a castration threat. The psychodynamics of the symptoms of sleeplessness, dreams and ruminations deserves notice. Sleeplessness probably represents lack of ability to accept the safety of the present situation; the repetitive dreams are attempts at belated mastery of the traumatic situation; the ruminations an attempt to find a new solution for meeting similar frightening situations.

Symptoms Similar in Civil Life

The symptoms of psychologic disturbances seen with severely threatening traumatic occurrences of civil life are similar to those seen with fear reactions in war situations. The symptoms of ¹anxiety, ²post-traumatic nightmares and restriction of contact with situations, which are anxiety provoking, is characteristic of both conditions. The symptoms produced are those of disturbed or absent function of higher centers. The absent or the diminished ego, (the disturbed integrative functions of the higher centers) may be manifest in syncope, or varying degrees of stupor as protection against further incoming or stimuli, amnesic disturbances, perplexity and confusion. Symptoms produced by previously inhibited lower center functions becoming dominant are spells of uncontrollable emotion; anxiety, crying, weeping shouting and rage.

Repetitive dreams with disturbed sleep and difficulty in falling asleep is characteristic. The traumatic situation is repeated over and over in dreams. Sexuality is decreased and attention is focused on mastering the environmental threats. The emotional impact is a crucial element in symptom production, the actual imagery just before impact of pain, the sight of blood, the period of unconsciousness and recovery, the anticipation of death of mutilation and the attitudes, statements and anxieties of those in immediate contact are responsible for the patient's care all contribute background material for ruminations about the injury. Rumination about the incidents just prior to and at the time of the accident are classical symptoms in traumatic neuroses. The type of acute affect expression most likely to be seen later is that which was intensely expressed at the time of the traumatic situation. Autonomic disturbances covering the total range of psychophysiologic reactions are present. The quantitative

variation from patient to patient is considerable. Among the symptoms are profuse perspiration, with droplets running from the armpits and from the groin, in severe disturbances, pallor, coldness of the extremities or redness and excessive warmth, pupillary dilatation, tachycardia and arrhythmias, gastrointestinal hypermobility, increased urinary frequency and urgency and hyperventilation. Motor system symptoms such as tremors throughout the entire body or limited to one extremity, muscular spasm with markedly exaggerated reflexes, spasticity, postural torsion and gait disorders and speech impediments are common but vary in intensity from mild hyperreflexia to total spastic immobility.

Successful mastery is obtained by meeting the external threat through a direct expression of countermeasures to effectively cope with the problem, for instance by being obsessively cautious. Failure results in the use of regressive measures such as passive dependency and a state of helplessness and phobic constriction of activities.

Precipitation and Aggravation of Neuroses by Trauma

The precipitation of a neurotic disturbance which is minimally classic for the traumatic neuroses and more characteristic of the usual psychoneuroses of office practice is frequently alluded to as a traumatic neurosis. The neurosis precipitated by trauma are primarily those neurotic syndromes diagnosed as anxiety neuroses, conversion hysteria, obsessive compulsive neuroses and phobias. Psychophysiologic disturbances are usually included. The trauma may be minimal or in some instances severe. The symptom syndrome which appears following the accident is characteristic of one of the disturbances noted above. The historical data indicates the presence of a psychoneurotic disturbance prior to the accident but with a degree of compensation so that reasonably effective social, sexual and work experiences were characteristic of the living pattern. Traumatic neuroses symptoms of the classical syndrome are minimal or totally absent. The sexual disturbances are more likely to express the psychosexual conflicts of the pretraumatic personality than the abrupt loss of and withdrawal of interest characteristic of the traumatic neuroses. The secondary gain value of the psychoneurotic disturbance may include in addi-

tion the acceptance of a traumatic explanation of the disability as a means of elevating pride and self esteem. "I am not an ordinary neurotic, I am justifiably sick as the result of this injury."

Patients with psychoneurotic and psychophysiologic disturbances which have been overtly disturbing and disabling may become more severely decompensated following a traumatic experience. The psychoneurotic syndrome prior to the trauma is readily documented by the history and the evidence afforded by previous medical care. The syndrome following the accident merely aggravates the already disabling clinical condition and traumatic neuroses symptoms are minimal, were minimal in the immediate post trauma period and became quiescent or were never present. The disability is usually totally out of proportion to the physical damage to the patient. As with neuroses precipitated by trauma the readiness to accept the trauma as an explanation for illness may be found. The function of the traumatic explanation to prevent the loss of self esteem and pride in accepting a diagnosis of psychoneurotic as the cause of the disabling illness needs careful appraisal in therapeutic management.

Treatment of Traumatic Neuroses and Psychological Disturbances Following Injury

The treatment of traumatic neuroses should be associated with an awareness that:

There is a limited adaptability to withstand stress in every individual and that a traumatic neurosis can be created in every individual, that injury to other workers tends to act continuously as a stress to the uninjured by destroying their sense of security and mastery over the environment, that individuals with limited skills and ability to choose new occupations are more likely to develop a phobic aversion to return to the work situation in which they were injured and the traumatic neuroses syndromes will be activated with any real possibility of returning to work, that hazardous occupations tend to create counter phobic defenses of denial:

"It can't happen to me"—which may make the individual vulnerable to seemingly minor physical assaults, and that previously experienced trauma tends to create a selective vulnerability for situations in which a similar or identical phy-

sical assault may occur. Every physician should try to evaluate his relationship to the injured person. The industrial employee may look upon the physician as a person of knowledge, skill and authority and feels that he will act to help him and will, like a mother or father, minimize the dangers from the injury and the hazards of industry. On the other hand, the physician may find himself in the position of being considered as opposed to the employee's welfare. The surgeon must evaluate and manage these manifestations of the patient-physician relationship. It is obvious from the previous material that much can be done in the prevention of traumatic neuroses. Our efforts should be directed toward increasing the safety of all workers. All the emphasis should be in the nature of positive and reassuring messages rather than those which place the stress on the hazard. We should emphasize the desirability of being safe through wearing a safety helmet rather than the danger from falling objects. The treatment by the industrial surgeon is usually directed at the acute case in the period immediately following the accident. The aim of the physician should be to create an atmosphere of assurance and rest. It is imperative that all pain and discomfort should be alleviated to the greatest extent possible. Sedatives should be used freely if they are not contra-indicated. All efforts should be directed at making the patient feel that his environment is safe and secure. There should be a maternal nurse-like attitude on the part of the physician, with an interest in the details of the comfort of the patient with regard to sleep, warmth, food and other personal needs. Careful questioning about the incidents occurring at the time of the accident will help to clear up amnesic reactions which may become dissociated. A kind reassuring attitude must be maintained by the physician while the accident situation is recounted and a careful appraisal of the patient's ability to deal with the anxiety created is important. The patient should not be pushed on to a point beyond his tolerance. The traumatic incident should be reviewed in detail, beginning with the peripheral incidents and increasing the awareness of the details within the range of the patient's ability to tolerate the anxiety created. The patient should be praised for every achievement, encour-

aged to achieve more, and reassured of his ability to master the environment.

Noxious Effects of Medical Management

It is important to stress some of the noxious effects of medical management of the injured individual, since the same factors of patient-physician relationship which can result in cure may likewise result in further disability. Questions about the injury are frequently so worded as to be psychonoxious in their effect on the patient. Such questions as:

"Do you have a headache?", "Can you walk?", "Can you see?", are frequently asked the patient with head and other injuries. Such questioning leads the patient to feel that the disabilities mentioned by the physician are to be expected, and might lead to further disability. In one case with which I observed closely, the head-injured patient was asked the question, "Do you have any headaches?" This question was repeated daily for several weeks. Questions should be asked so as to obtain information with the giving of symptoms. They should be followed by praise and encouragement for absence of symptoms, on the other hand one must be exceedingly careful not to produce increased resentment and irritability toward the physician and the employer by such statements as:

"There's nothing wrong with you."

The importance of such elements of therapy as the secondary gain through illness should point to the need for rapid monetary settlement, if disability results. On the other hand, the phobic reactions of the individual should be sufficiently respected so that an employee is not constantly urged to return to a job he can no longer face without anxiety. The individual should be placed in positions of safety from which he gradually can be moved closer to the scene of the injury, with the helpful and reassuring attitude of the physician, the foreman and others. Whenever the phobic reaction can be mastered sufficiently to permit immediate return to the same job, this should be considered desirable.

The patient whose symptoms become somewhat fixed by time may require the help of a psychiatrist. The problem becomes one of treating the basic neurotic conflicts of the individual and the restric-

tion of the potentiality for adaptive behavior due to injury, the uncovering of the repressed material about the injury which is anxiety-provoking, and its incorporation into the total personality free from dissociative tendencies.

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Laws and More Laws

Countless studies have shown that so-called "generic equivalents" are often not equivalent but this seems to be a matter of little or no concern to the chairmen of key congressional committees. These gentlemen, many of whom don't know an aspirin tablet from a hemicorporectomy, have decided that generic name drugs are good enough for Titles 18 and 19 patients. (They probably believe that they are good enough for one and all, but as yet they cannot tell the physician what to prescribe for patients who aren't under federal health care programs.)

The nation's physicians and dentists currently write about 1 billion prescriptions a year and nine out of every 10 specify a product by brand name. Physicians don't do this as part of a determined effort to increase the cost of medical care or just because it's "easier." They do it because they want their patients to get "just what the doctor ordered"—and not a bargain-basement drug that may cost a little less. Why does it cost less? Because the manufacturer may have cut a few important corners or put less emphasis on quality control. Or perhaps he's a "me-too" manufacturer who does little or no research, preferring instead to ride on the research coattails of an established firm that has spent hundreds of thousands of dollars on an effective, first-line product. Editorial. *Postgrad. Med.* (Feb.) 1967.

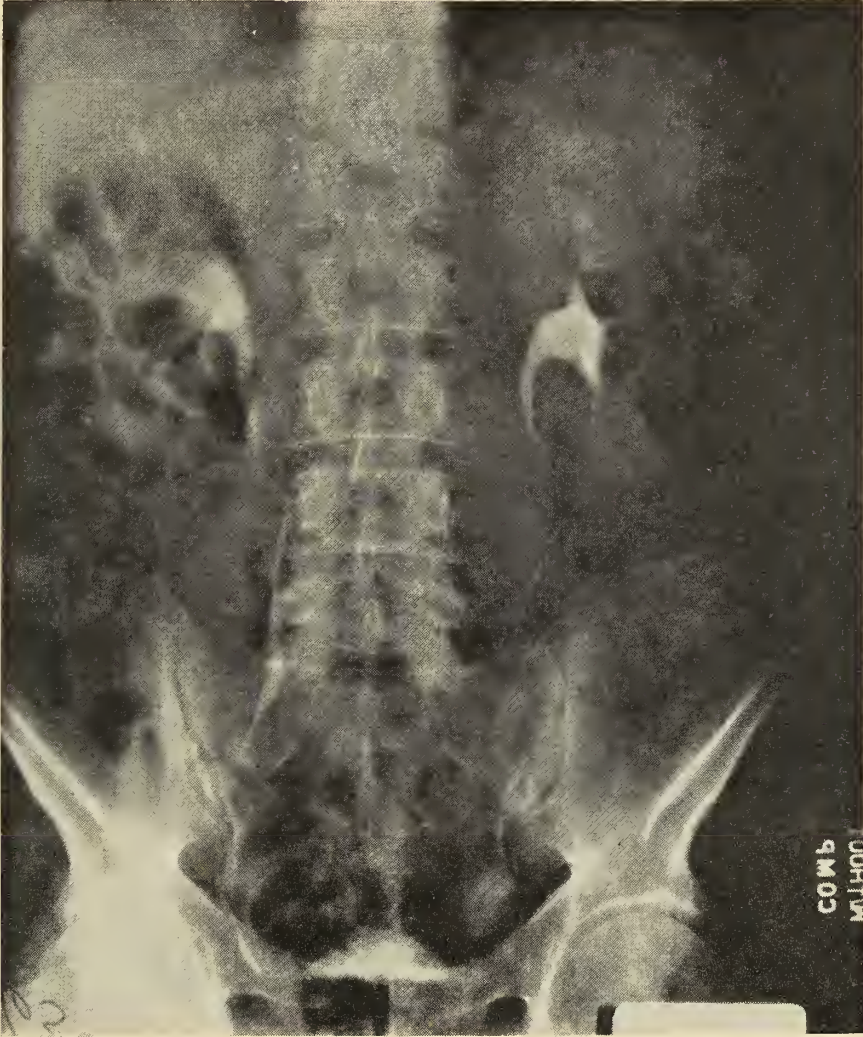
General Practice

Good general practice now and in the future is essential to the welfare of any country aspiring to a uniformly high standard of living. This is confirmed by the authoritative report of the Review Body in the United Kingdom which so sharply criticised the withdrawal of doctors from general practice there. In New Zealand the wisdom of earlier years has evolved a system sufficiently stable to be free from the crises recurrent in the English medical scene. Nevertheless (and this the profession has endorsed) there is strong reason to review our own affairs on a wide basis. In the most vital of sectors, general practice, a good start is made with the report of the Auckland group which has exhaustively surveyed the field in their own bailiwick. This fifty-page statement will be widely studied and the informed views about it will come from general practitioners themselves. As ever the Press has exposed to the public eye only the raw financial fragments and the thoughtful dissection in the report of what a doctor does from day to day goes unremarked. The picture that emerges (and the pattern would be repeated in other parts of the country) is of doctors who work longer hours than their counterparts overseas, spend more time with individual patients, visit more homes and die sooner. Is it any wonder there is reluctance on the part of many of our younger graduates to engage themselves in this frustrating scene?

Christchurch. *The New Zealand Med. Jl.* (Oct.) 1966.



THE VIEW BOX



By LEON LOVE, M.D.

*Director, Department of Diagnostic Radiology, Cook County Hospital,
and Associate Professor of Radiology, Chicago Medical School*

This 65 year-old W/M entered the hospital with complaints of frequency and nocturia. Physical examination revealed a 1+ prostatic enlargement and a poorly defined deep seated mass in the left abdomen. Laboratory results were within normal limits. An I.V.P. (Fig. 1) was done.

WHAT'S YOUR DIAGNOSIS?

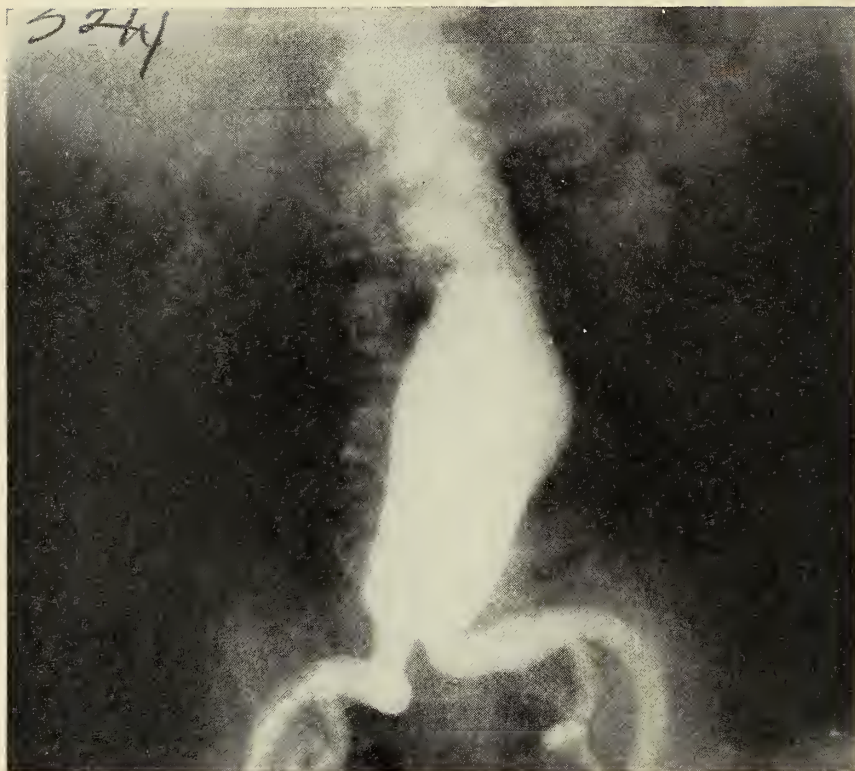
1. Retroperitoneal sarcoma.
2. Retroperitoneal lymphoma.
3. Aneurysm of the abdominal aorta.

(Answer on page 818)

—THE VIEW BOX—

DIAGNOSIS AND DISCUSSION

(Continued from page 817)



DIAGNOSIS: Aneurysm of the abdominal aorta.

The striking feature of the I.V.P. is the presence of a mass somewhat lateral from left transverse process of L4. This mass causes obvious pressure and lateral deviation of the upper 1/3 of the left ureter.

Retrograde aortography via the femoral artery route was performed and demonstrated a fusiform aneurysm of the distal abdominal aorta down to the level of the iliac arteries. The aneurysm accounted for the deviation of the ureter noted on the I.V.P. The renal arteries were intact and outside the confines of the aneurysm. This finding permitted resection and dacron replacement.

The presence of a calcification at the periphery of the mass deviating the ureter would have been helpful in the diagnosis. However, in its absence, aortography is the only diagnostic method available.

The insertion of a catheter through the site of an aneurysm is rarely associated with morbidity and if surgery is contemplated gives the surgeon the most information regarding the scope of his operative procedure.

Doctors, Clergy And The Patient

On these pages during the succeeding months will appear a series of articles on the correlation of medicine and religion. These will reflect the activities of the state society Committee on Medicine and Religion which in turn will follow the precepts of the new AMA Department on Medicine and Religion. Realizing that man is a complex organism composed not only of tissue but of soul as well, the new plea is to consider the "Whole Man" in our treatment of his ailments.

In times past the average person lived a simple life. He had his general practitioner who not only looked after his physical ailments but provided much guidance and solace in times of stress. He had his church which gave him strength and courage to face the trials of life. He usually lived and died in the same environment.

In the modern world, all is changed. The average family moves every five years. Not only is the individual removed from his family physician but from his pastor as well. The modern "physician" is different since "he" usually is a composite group of specialists—none of whom the patient ever really gets to know. The church, too, somehow has changed and in the businesslike atmosphere of a large church the new member may never really feel at home.

The individual, however, is essentially the same. His tissues develop the same af-

flictions, but with the newer medicine his chance for physical rehabilitation is much greater than formerly.

The neglect of his other self—his emotional side, his fears, his sense of values and his soul may so disturb him that scientific care may either fail or, even if successful in maintaining life, leave him lost to future happiness. All physicians on reflection can recall patients who have died from no explicable cause or after physical recovery, have lived an unhappy and useless life, perhaps to end it later by their own hands.

The practice of medicine today depends primarily upon the disciplines of science. The major search is for organic disease, but man is more than flesh and bone. Since it is essential that the "Whole Man" be cared for if his life is to be both healthful and meaningful, it is necessary that the medical profession join hands with the clergy in providing total care.

In subsequent articles specific areas will be presented in which joint efforts are needed. These will include the clerical-medical team concept, the education of the physicians to the role of clergymen in the health picture, the needs of the patient facing surgery or impending death, and many other areas in which the welfare of the patient requires the cooperative efforts of the two professions.

—J. ERNEST BREED, M.D.

EDITORIALS



DILEMMA IN THE MEDICAL DEPARTMENT

One of the most frustrating experiences faced by an industrial medical department centers about employees who prolong minor illnesses. They take two weeks to recover from a mild respiratory infection or an attack of gastroenteritis.

The medical director accedes to the judgment of the family physician but is pressured by the foreman or boss who is sure the "sick" employee is goldbricking. Nothing is gained when the illness is protracted beyond any demonstrable value to the worker. Overemphasis on rest often encourages psychoneurosis and adds fuel to the anxiety of those having constitutional inadequacy.

On the other hand, many of these patients are difficult to handle. Prolonging an illness is tempting, especially when the summer cottage needs repairs or the home a coat of paint. There are many remunerative benefits to illness and it is difficult to convince a person that he is well enough to work when more money is made through sickness compensation. Returning these patients to work is therapeutically sound, but the attending physician is not always acquainted with the individual's job and the effects of absenteeism upon the morale of the rank and file. In many industries, not

only does the sick employee get his full wages, but his substitute also must be paid.

Although mental illness is a problem, several companies are quite liberal in hiring persons convalescing from depressions and schizophrenia. Some psychiatrists consider work an emotional boost for the patient but they fail to look beyond the walls of their consulting rooms. The patient's well-being comes first but not when it interferes with business. The employer is likely to be more sympathetic when he knows what to expect and how to help the employee return to the job.

Prolonged disability also occurs when the family physician insists on conservative measures long after they have served a useful purpose. Examples include numerous recurrences of peptic ulcer attacks requiring 75 to 125 days of disability annually. Running a business with a employee who is disabled one-third of the time is difficult. The medical director wonders what the attending physician would do if his office nurse was sick this often. The climax comes when the worker is finally seen by a surgeon and finds out that he could have been spared years of misery if surgery had been done earlier.

(Continued on page 826)

SOCIO ECONOMIC *news*

A service of the Public Relations and Economics Division

Blue Shield Payment Program Approved by ISMS Delegates

Support of a Blue Shield program which provides for payment of usual and customary fees to physicians treating Illinois steelworkers and their families was voted by the House of Delegates at the ISMS annual meeting. The House accepted a reference committee recommendation that it support "... this and any insurance carrier program in its application of the usual and customary fee concept ... incorporating free choice of physicians in future insurance programs." The House agreed that any dispute over fees in such programs should be referred to a committee of the local county medical society for adjudication. Blue Shield, in asking ISMS support of its program, agreed to such adjudication and also agreed to abide by the decision of the medical group's review committee in all fee disputes. Robert M. Redinger, Blue Shield's executive vice president, expressed the plan's appreciation for the House action. "Under this new program," he said, "the physician will be paid his usual charge for the service he has provided so long as it is consistent with the fees charged by his colleagues for that service. At the present time, this concept would not apply to other contracts of the Blue Shield plan in Illinois."

* * *

Delegates Approve Extension Of Welfare Payment Program

In other actions at the annual meeting, the House of Delegates approved the continuation of the program under which doctors treating public aid patients are paid their usual and customary fees by the Illinois Department of Public Aid. The program, the House said, should be reviewed "at appropriate intervals." On the legislative front, the House voted to oppose the imposition of a state tax on medical services to Illinois citizens, as proposed in Senate Bills 1331-1336. Delegates agreed that physicians and others engaged in the healing arts should not be subject to a four percent tax on all billings. In the area of utilization review, the House adopted a position that ISMS does not object to the reimbursement of physicians serving on utilization committees. Reimbursement would be at the individual option of the hospital staff, delegates agreed.

**Title 19 In Illinois
Costs \$87.9
Million**

The first-year cost of Title 19 of the Medicare Law in Illinois was \$87.9 million, according to a recent report. The average cost for each of the 525,000 Illinoisans served under the program was \$167. The total cost of the program was shared equally by the federal and state governments. Total federal-state spending across the country for medical assistance reached an estimated \$1.82 billion in fiscal 1967.

* * *

**\$100,000
Appropriation to
Board of Education**

The Illinois Board of Higher Education has been given a \$100,000 appropriation to help finance a comprehensive study of the state's medical and health-related educational needs. The study will pay particular attention to what measures may be needed to assure "an adequate number" of general practitioners to meet the state's needs. The bill appropriating the study funds stipulated that no more than \$65,000 can be spent until an equal amount has been received from foundations and other sources.

* * *

**Ophthalmologists
Should Bill IDPA Usual
and Customary Fees**

Illinois ophthalmologists can expect to be paid their usual and customary fees for eye examinations of public aid patients. Some ophthalmologists continued to receive the old fee schedule allowance of \$7 for any eye examination after initiation of the Public Aid Department's new policy of paying usual and customary fees. Harold O. Swank, Director of Public Aid, said the payments resulted from "our failure to modify billing procedures in this area." Modification has been made and all bills by ophthalmologists—except those to determine blindness—are being paid under the NEW reimbursement program. The \$10 fee allowance still applies for an examination to determine blindness.

—GAYLEN LAIR AND MARVIN SCHRODER

What Physicians Should Know About Bank Charge Cards

By MARVIN SCHRODER

Illinois State Medical Society Division of Public Relations and Economics

The symbol at right has—since last October—became almost a part of the landscape in Illinois and adjoining states. It's the symbol of the Midwest Bank Card System—a new method of consumer financing introduced by several of Illinois' leading banks. More than 3½ million Illinois residents now hold bank charge cards, and more than 40,000 business and professional firms accept them as payment for goods and services. Now—having been



Richard E. Kelley

given conditional approval by the AMA Judicial Council—banks issuing the cards want physicians to accept them as payment for professional services. This has prompted many inquiries from physicians to the ISMS headquarters office. How do the plans work? What are their advantages to physicians? To obtain these answers, the ISMS Division of Public Relations and Economics interviewed Richard E. Kelley, vice president of the First National Bank of Chicago, and general manager of the bank's FirstCard department.

Q. Mr. Kelley, what is the Midwest Bank Card System?

A. It's a compatible bank card plan organized by several leading banks in Illinois, Indiana and Michigan. Each member bank in the system issues its own charge cards under a distinguishing name.

Q. Is there significance to that word "compatible?"

A. Definitely. It means that any professional service or retail business participating in the program may honor any Mid-



west Bank Card—no matter which bank issued it. And, of course, it means too that the consumer can use his particular card at any business or professional office displaying the MBC symbol.

Q. Will the Midwest System eventually develop into a national bank charge card network?

A. I believe it extremely likely that it will, especially considering that in less than one year the number of banks sponsoring bank charge cards in the U. S. has increased from 50 to more than 1,000. There are bank charge card systems operating successfully on both the East and West coasts and I think it reasonable to expect that these regional systems will eventually develop into a national network. Then, one bank card will be acceptable across the country, and throughout Europe as well.

Q. Mr. Kelley, what advantage is there to a physician agreeing to accept bank charge cards?

A. We think there are several—from both time and money viewpoints. Perhaps the

most important is that the physician's checking account is immediately credited for all charge transactions—and the billing and collection of these charges becomes the bank's responsibility.

Q. How is this done?

A. The Midwest Bank Card System is basically a clearing house for all the charge slips generated by bank card users. The patient presents to the doctor's assistant any one of several MBC System bank cards. The assistant completes a charge slip—the patient is given a copy—and the slip is then mailed to the bank with which the doctor has signed a participating agreement. This bank immediately credits the doctor's account with the amount of the charge, then channels the charge slip back to the bank which issued the patient's card. The card holder is billed once a month for the total amount charged that month—no matter where the charges are made.

Q. What does this banking service cost the doctor?

A. The bank does charge a service fee, of course. It's based on a small percentage of each month's total charge deposits. The FirstCard plan has set up a special department to accommodate professional people and has established a service fee of three percent a month for Illinois doctors.

Q. Does this new payment method increase the patient's cost?

A. No—if the amount he charges is paid within 25 days of the date of billing.

Q. But what if the patient can pay only a portion of the total charge?

A. Then he may budget his payments for a monthly service charge of one-and-a-half percent of the unpaid balance. This option, we believe, can be helpful to patients who find it necessary to spread payments over several months. And the rate he pays is below that charged by many lending institutions.

Q. Is there a limit to the amount a patient may charge with a bank card?

A. Yes, but in some cases arrangements may be made with the bank to increase this limit for special expenses or larger purchases.

Q. Mr. Kelley, in the case of a patient who doesn't pay his charges, what pressures would the banks apply to collect the debt?

A. Attempts to collect would be made, of course. But let me emphasize that card-

sponsoring banks are among the largest and best in Illinois, and collection problems would be handled in a professional manner.

Q. What has been the experience so far with uncollected debts?

A. Because of the credit requirements established by the banks and careful screening in distribution of the cards, only a very small percentage of the total charges have gone uncollected.

Q. Should a doctor accept a bank charge card for costs covered by medical-hospital insurance or welfare allowances?

A. This is an area that needs further clarification. Consequently, our advice to doctors is that they not accept the cards for fees covered by either insurance or welfare benefits.

Q. What about Medicare recipients with bank charge cards?

A. The federal government has yet to issue a statement on the acceptability of bank charge card receipts as the basis of reimbursement under Medicare. Our advice is against accepting the cards from Medicare patients at this time.

Q. What's the procedure if a doctor decides he wants to participate with MBC?

A. He first signs an agreement with one of the sponsoring banks. Then, a bank representative will contact him to explain the system and provide him with the necessary charge slips and other forms. Incidentally, because of the special requirements of the medical profession, FirstCard has modified its program to provide special professional charge forms for a doctor's use.

Q. Must the doctor open an account with the sponsoring bank?

A. This will be done for him. When the bank receives charge slips from the physician, the amounts on the slips will be credited to this account. Of course, the doctor is free to draw on this account and to transfer the funds to any bank of his choice.

Q. Is it necessary for the doctor's assistant to record the charge each time a patient visits?

A. That depends upon the bank with which he has signed an agreement. FirstCard has a pre-authorization procedure whereby a patient may authorize his doctor to sign the charge slips in his name. This

(Continued on page 860)

Leiomyoma of the Sigmoid Colon with Perforation Into the Retroperitoneal Space

By VICTOR R. JABLOKOW, M.D. AND RAY DIETER, JR., M.D./HINES

A Case Report

Leiomyomas are benign tumors of smooth muscle origin. They may occur along the entire gastrointestinal tract. They are more frequent in the esophagus and stomach, but colon and small intestine are also commonly involved.^{1,2}

The leiomyomas are usually well circumscribed, firm lesions. They may be present within the wall, may protrude from beneath the mucosa, may be located on the serosal surface, or may have dumbbell form (Griggs).³ The small leiomyomas cause no symptoms and are diagnosed either incidentally at surgery or are found in autopsy material. However, the tumors may attain a rather large size and become symptomatic, especially in the stomach or rectum.

MacKenzie⁴ in 1954 reviewed the literature on leiomyomas and leiomyosarcomas involving the colon, excluding those in the rectum. From 24 benign leiomyomas, nine were present in the sigmoid colon, six in the transverse colon, and four were found in the ascending colon. Reviewing the cases of the leiomyomatous tumors of the alimentary tract from Memorial Hospital in New York from 1935 to 1961, Quan⁵ found that from 119 leiomyomas of the gastrointestinal tract, 77 were present in the stomach, 14 in the small bowel, nine in the colon, and 19 in the rectum. The myomas may cause intestinal hemorrhages after ulceration of the overlying mucosa or intestinal obstruction when they attain a large size. Perforation of the leiomyoma is a rather unusual occurrence. We would like to report an example of such a complication.

A 67-year old male was admitted to Hines Veterans Administration Hospital with a history of left lower quadrant pain for two weeks, aggravated by body movement. The patient had no constipation or diarrhea but had passed some blood per rectum two weeks prior to admission. He was anorexic and had no nausea or vomiting. The patient lost 10 to 12 pounds of weight during the three weeks prior to hospitalization.

Physical examination on admission revealed a hard, tender, smooth, sausage-shaped mass measuring approximately 12 by three inches located in the left lower quadrant. Rectal examination was negative. There was no rebound tenderness, and bowel sounds were noted to be active. Laboratory studies on admission demonstrated white blood cell count of 16,000, with 87 percent polymorphonuclear leukocytes, 12 percent lymphocytes, 1 percent monocytes. Hemoglobin was 14 percent, hematocrit 42 percent. The urine sediment contained many white and red blood cells, and x-ray films of the abdomen showed moderate to marked small and large bowel distention. There was a small amount of air in the sigmoid colon area, and there was air in the ampulla of the rectum. Findings were suggestive of ileus. Barium enema examination three years previously had demonstrated numerous diverticula of the descending colon. Other laboratory findings were not contributory. Differential diagnoses included acute diverticulitis and carcinoma of the colon.

The patient was treated with antibiotics and sulfanamides with initial success, evidenced both symptomatically and also in reduction of size and tenderness of mass. However, his temperature began to spike, and he expired ten days after admission with a terminal temperature of 107.6°F.

From the Department of Pathology and Surgery, Veterans Administration Hospital, Hines.

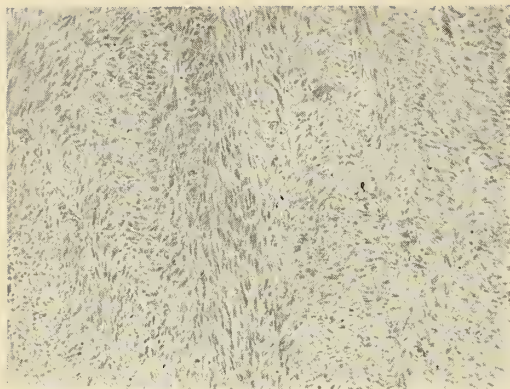


Fig. 1. Photomicrograph of the tumor showing interlacing bands of smooth muscle.

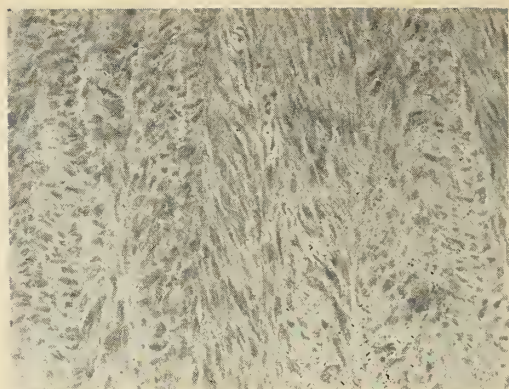


Fig. 2. High power photomicrograph showing cellularity of the tumor and absence of mitotic figures.

Pertinent autopsy findings were limited to the abdomen. There was a roughly round nodular tumor mass measuring over 2 cm. in diameter located in the sigmoid colon with retroperitoneal perforation and abscess formation. The abscess contained approximately 100 cc. of foul-smelling purulent material. There was also an acute peritonitis present. The perforation was not associated with a diverticulum or diverticulitis.

Histologically the tumor consisted of well-differentiated smooth muscle fibers which had an interlacing pattern (Fig. 1). The tumor was focally cellular, but there was a relative lack of mitotic figures. The nuclei were elongated and had regular outlines (Fig. 2). No anaplasia was present. Occasional mycotic figures could be found only after prolonged search. The mucosa over the tumor was ulcerated. The tumor had involved the entire thickness of the colonic wall and had perforated into the retroperitoneal space. There were superficial areas

of hemorrhage and necrosis. The retroperitoneal space revealed marked inflammatory infiltrates, histiocytic and fibroblastic reaction. The inflammatory cells included lymphocytes, plasma cells and eosinophils. Masson's Trichrome stain confirmed that the tumor was of smooth muscle origin with small amounts of fibrous tissue scattered throughout. Reticulum stain was not contributory. Microabscesses were found in the liver and kidney on histologic examination.

Discussion

Perforation into the retroperitoneal space with retroperitoneal abscess formation is a rare complication of a leiomyoma of the colon. Scattered reports of lower intestinal leiomyomas with hemorrhage or obstructive manifestations^{1,3,6} are found in the literature. However, no instances of perforation with abscess formation were found in the American literature since 1954.

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Psycho-active Drugs

(Continued from page 787)

serious and marked by psychomotor excitation.

(8) Distrust any reports of therapeutic efficacy which have not contained in the experimental design a placebo group under double blind conditions. At least 70 per cent of emotionally disturbed children will be significantly improved at the end of three months without any kind of treatment.²¹

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The Doctor's Library

WARD PROCEDURES AND TECHNIQUES. Philip Cooper, M.D., Appleton-Century-Crofts, New York, 1967, \$6.75.

This excellent book provides a basic introduction to frequently used hospital and office procedures. The main emphasis is clinical. It is only indirectly concerned with the specific activities of the operating room, radiology department, and other specialized laboratories. The procedures are described in detail and augmented with excellent drawings.

The book is intended to assist clinical clerks, interns, and residents but will prove most helpful to physician instructors. There are 30 chapters beginning with ward rounds and clinical charts and ending with the removal of foreign bodies in the eye and nasal packing. The chapters on pre- and postoperative care, pulmonary function studies, local anesthesia, angiography, catheterization, thoracentesis, endoscopy, management of abdominal "ostomies," tracheotomy, resuscitation, and administration of oxygen and fluids, are complete in themselves. Other procedures dealt with are currently accepted as standard.

T. R. Van Dellen, M.D.

Northwestern Psychiatrist Says Some 'Beatniks' Now Society's Leaders

In a world of Be-Ins inhabited by hippy, trippy and teeny-bopping revolutionaries, society's old enemy—the "beatnik"—appears to have dropped out of sight.

Has he sold out to Suburbia and the Establishment? Is he a middle class beater instead of a martyred beat?

Very possible so, speculates Dr. Jules Masserman, co-chairman and professor in Northwestern University's psychiatry-neurology department in the current issue of the American Medical Association's Archives of General Psychiatry. However, he adds this qualification:

Very possible so—if he was an "upbeatnik," and maybe so if he was a "downbeatnik." However, the "offbeatnik" is very likely still off and dropped out.

In an editorial, "The Beatnik: Up —, Down —, and Off —," Dr. Masserman dignifies the term "beatnik" as the proper scientific label for referring to all manner of rebellious young people. The newer labels are merely beatnik subunits. For example: Hippies and trippies (who limit their trips to the LSD variety) belong to the extreme wing of the "off-beatniks." They comprise the "way-off beatniks."

Teeny-bopper only designates the extreme youth of the person so labelled. They could develop in any direction later—off, down or up.

And what of the poet Allen Ginsberg, who officiated at a massive outdoor Be-In of hippies and trippies recently in San Francisco (and closed it by blowing a conch shell as the sun sank into the Pacific)? Up? Down? Off?

"That's no more than exhibitionism," Dr. Masserman said.

Characteristics applicable to all classes of beatniks, wrote Dr. Masserman, include strange speech and clothing patterns, abuse of drugs and stimulants ranging from alcohol to hallucinogens and "aberrant eroticisms (brazen exhibitionisms, flagrant fetishisms, public promiscuities and defiant deviations in sexual techniques, objects, and partners)."

But there the similarities end. Here is how Dr. Masserman distinguishes between the three main groups:

UPBEATNIKS—"This group, even with their occasional beards, tresses, playreadings, placards and protest-marches, are the best of the lot. Basically earnest, energetic, intelligent and well-intentioned, they are not an inconsiderable help in prodding us oldsters to review our smug hypocracies and revise our medieval customs and conduct."

The up-beatniks will most likely be numbered among society's eventual leaders, he said.

DOWNBEATNIKS—"This describes the more consistent nonconformist who more articulately and rationally condemns the inequalities and injustice of our societies and, often with some courage and justification, rebels against them—sometimes to the extent of outraging our sensibilities, but only rarely violating essential provisions of our social and legal codes.

"The prognosis here is often favorable: With further maturity and increasing wisdom, most of them become good citizens, competent parents, and sometimes even staunch Republicans."

OFFBEATNIKS—"These we have already considered as the more seriously erratic, troubled and troublesome misfits, disharmonious with their own milieu and, despite their pretensions, contributing little that is truly constructive or original to our culture. . . . I have personally seen their almost stereotyped visages on both sides of the so-called Iron and Bamboo Curtains."

The physician and psychiatrist can only rarely help an off-beatnik and only occasionally a downbeatnik, he wrote.

The only effective treatment would be a preventive one "and would thus involve not only the education of the public toward more responsible parenthood, but also the amelioration of actual economic, social and political inequalities that breed successive generations of the disaffected among us."

Only the upbeatniks are "sufficiently self-critical to seek help from us or anyone else—whereas the others are often hysterically sure they are completely right and the world is all wrong," he said.

Almost any intelligent and sensitive physician
(Continued on page 830)

State Hospital to Expand Rehabilitation Services

Expanded rehabilitation services for patients at Chicago State Hospital will be made possible by a \$479,365 federal-state matching grant, Dr. Hyman C. Pomp, superintendent has announced.

Three new therapeutic workshop programs will be initiated as a result of the grant. Funds will be used for renovation of an existing building as well as equipment to provide a rehabilitation work setting for about 160 patients.

Three-fourths of the grant, provided by the U. S. Vocational Rehabilitation Administration, will be transmitted to the hospital by the State Division of Vocational Rehabilitation. The additional funds will come from the hospital's building renovation funds. The project is part of a continuing effort linking the activities of the Division of Vocational Rehabilitation with the rehabilitation services of the Department of Mental Health. "This will allow us to provide patients with the kind of meaningful, supervised work experiences that will hasten their recovery," Dr. Pomp said.

Presently, the hospital has a small therapeutic workshop program involving about fifty patients who do light assembly operations and other industrial projects. The hospital contracts with local industries and patients are paid for their work.

"Often a patient needs to revitalize his work habits and job skills before returning to society as a productive citizen. Our expanded rehabilitation program will move toward this objective," Dr. Pomp said.

A building on the hospital grounds which formerly housed a cannery and bakery will be refurbished to make way for the three rehabilitation facilities including a pre-vocational diagnostic center, vocational adjustment center and an electronics assembly shop.

The pre-vocational diagnostic center will serve 75 patients, allowing for an evaluation of skills and needs. With testing and counseling services available, special individual programs will be worked out to assist the patient toward recovery.

The vocational adjustment center will also serve 75 patients as a maximum rehabilitation unit, acting as a transition between the hospital and outside employment.

The electronics assembly shop will be

both a training and work program for about 10 patients. Since high employment potential exists in the Chicago area for persons skilled in electronics assembly, it is contemplated that direct placement with industrial firms can be accomplished.

Within the hospital, the program will be administered by John Miller, supervisor of the Rehabilitation Department.

The patient work programs will be carefully supervised by skilled rehabilitation counselors. Work experiences will be viewed as a part of the patient's total treatment needs.

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(Continued from page 801)

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Cancer Society Distributes Anti-Smoking Calendars

The decision of the Medical and Scientific Committee of the American Cancer Society, Illinois Division, Inc., to recruit physicians to distribute 100,000 1967 ACS calendars, stressing the risk of smoking, is proving a real success.

The letter from Chairman Dr. Robert L. Schmitz, associate clinical professor of surgery and coordinator of cancer teaching, Stritch School of Medicine and first vice president of the Illinois Division, asking for volunteers for this project went to 1,769 physician members of unit boards and other doctors who have furnished information for the society's cancer prevention survey.

By mid-February, 416 or 25 percent of the physicians from 93 of the 105 units of the division have responded with requests for 51,330 calendars.

With many physician members of unit boards spreading the invitation to local colleagues, Dr. Schmitz reports, "There seems little doubt that we will double our distribution figure—and certainly more than double the impact of the message."

The message:

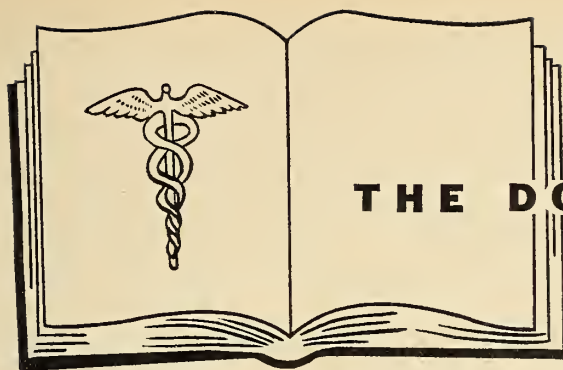
BE SMART! DON'T START!
BUT IF YOU SMOKE CIGARETTES
THE TIME TO STOP IS
NOW!

Beatniks

(Continued from page 828)

sician is qualified to help the beatnik who asks for help, he said.

Dr. Masserman is a councillor for the American Psychiatric Association, a former president of the American Academy of Psychoanalysis, the American Society of Biological Psychiatry and the American Society of Group Therapy and Psychodrama. He is chairman of the Illinois Psychiatric Research and Training Authority.



THE DOCTOR'S LIBRARY

SPONTANEOUS REGRESSION OF CANCER. Everson, T. C. and Cole, W. H. W. B. Saunders Company, Philadelphia, 1966.

This book is based on long-standing interest and experience in cancer and a review of the world literature since 1900.

Spontaneous regression of cancer is defined by the authors as "the partial or complete disappearance of malignant tumor in the absence of all treatment or in the presence of therapy which is considered inadequate to exert a significant influence on neoplastic disease." The authors do not wish to be misinterpreted as concluding that spontaneous regression need progress to complete disappearance of tumor nor that spontaneous regression is synonymous with cure. However, this collection of 176 patients with cancer who have demonstrated complete or partial remission does represent an imposing volume of evidence in humans of some degree of biologic control of cancer.

The duration of the recorded regressions of cancer varied. In 28 of the 176 collected cases, the regression was noted at autopsy, in the surgical specimen, and a statement of the duration could not be made. The period of remission varied in the remaining cases from less than six months (21 cases) to 10 years or more (22 cases). The distribution of cases in this series is weighted with the more unusual cancers. More than 50 percent of the collected cases of spontaneous regression of cancer occurred in four types of cancer: adenocarcinoma of the kidney (hypernephroma), neuroblastoma, malignant melanoma, and choriocarcinoma. Spontaneous remission, although

reported less frequently in the more commonly occurring cancers, was observed in cancer of the breast, cancer of the uterus, cancer of the colon and rectum, and cancer of the lung.

Possible mechanisms to explain the phenomenon of regression are included at the termination of each chapter on the specific type of cancer. The authors feel that a better explanation of what happened to these cancers awaits the discovery of new hormones, identification of specific antibodies to cancer, or possibly a new group of substances which are unrelated to either hormones or antibodies.

The book contains a current bibliography on the clinical reports of spontaneous remission from cancer and also on the immunologic investigation of these intriguing phenomena. The compilation of such a series of cases represents an enormous amount of work. To have available this collection of verified cases of spontaneous regression of malignant neoplasms is to be the recipient of an exciting gift.

The book is well illustrated, and the case reports are easily read. The documentation of various theories concerning the mechanism of spontaneous regression is complete. The authors conclude with an optimistic note: "The existence of spontaneous regression of cancer, in at least some cases, supports the concept of biologic control of cancer and reinforces the hope that a more satisfactory method of treating cancer than surgery or irradiation may be found in future years."

Paul H. O'Brien, M.D.

Dr. Sims Pioneers Breakthrough In Sex Education

ISMS Goodwill Ambassador Dr. SIMS—a pioneer in health education—adds the role of sex educator to his laurels with a new record album entitled, “When Your Child Asks About Sex.”

Produced by the ISMS Public Relations Committee, the album was released to the consumer public last month through the society’s Educational and Scientific Foundation.

“When Your Child Asks About Sex”—which co-stars Dr. Max Klinghoffer as Dr. SIMS, and Chicago radio personality Mal Bellairs (WBBM) and his wife Jo as the inquiring parents—sells for \$4.95.

Copies of the single, long-play record—and accompanying booklet—will be distributed through medical, service, church, school and parents’ groups, as well as chain stores throughout the state.

PR Committee Chairman Dr. Leo P. A. Sweeney described the record as a “new and needed approach to sex education because it explains what every parent should know before attempting to assume the role of sex educator in the home.

“As far as we know, this is the first educational album of its kind prepared and officially endorsed by a medical society,” Dr. Sweeney said. Emphasizing its value for parents, he added:

“With today’s greater intellectual and moral freedom, it is difficult for parents to be certain that they are giving their children a proper sex education. Many parents need the help and advice of a physician in this regard, but can’t take the time to visit him. With this new album, ISMS makes it possible for the physician to ‘visit’ parents in their own home.”

Dr. Sweeney stressed that the album is “distinguished by its thoroughness, frankness and dignity. From the first questions

of the pre-schooler to the sophisticated query of teens, it provides answers that children will understand and appreciate.”

Among the subjects discussed in detail are: menstruation; erection; sexual intercourse; pregnancy; the process of birth; sex hygiene; nocturnal emissions; masturbation; and sexual abnormalities.

“Every parent who listens to the album will be better prepared to answer his children’s questions about sex,” Dr. Sweeney said. “More importantly, he will be able to anticipate his children’s needs for sex information at every age, enabling him to better assume the role of leader in keeping sex education a wholesome part of family life.”

Complimentary single copies of reprints of two sex education articles which appeared in recent issues of AMA publications are now available on request from the Department of Health Education. “The Role of the School and the Community in Sex Education and Related Problems” by Thomas E. Shaffer, M.D., appeared in the February, 1966 issue of *JAMA*. “The Home, the School, and Sex Education” by Marie Hinrichs, M.D., Ph.D., and Robert Kaplan, Ph.D., appeared in the February, 1966 issue of *Today’s Health*.

To help medical societies establish campaigns to combat venereal disease in their communities, the AMA’s Health Education Department offers single copies of its special kit on VD. Designed for medical societies wishing to conduct comprehensive, community-wide health education campaigns, the kit contains 20 different types of promotional materials, including radio and television spot announcements and suggested scripts for special programming, speeches for physicians, newspaper articles and suggested editorials.

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Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
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Cyanocobalamin	1.5 mcg.
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Contains 15% alcohol

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Each MEDITRIC Tablet or Capsule contains:

Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
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Orally active, water-soluble conjugated estrogens derived from
pregnant mares' urine and standardized in terms of the weight
of active, water-soluble estrogen content.

MEDITRIC helps keep the older patient alert and active;
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WARNING: Some patients with pernicious anemia may not
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cessation of response predictable. Periodic examinations and
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SIDE EFFECTS: In addition to withdrawal bleeding, breast ten-
derness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female*: 3 teaspoonfuls of
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In the female: To avoid continuous stimulation of breast and
uterus, cyclic therapy is recommended (3 week regimen with
1 week rest period—Withdrawal bleeding may occur during
this 1 week rest period).

In the male: A careful check should be made on the status
of the prostate gland when therapy is given for protracted
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Opinions and Reports on Medical Ethics

Ever-changing influence of consumer trend, government involvement, socio-economic interaction, and scientific progress will provide increasing opportunities for review and renewal of acquaintanceship with principles of medical ethics by all physicians be they in groups, clinics, or individuals—and be they great and prominent or small and unknown.

The principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

As prologue to articles on ethics dealing with specifics appearing in subsequent issues of the ISMS Journal, the following is reproduced.

"Ethical" and "unethical" as used in its opinions and reports, and in the resolutions of the AMA's House of Delegates, were adopted by the House during the Clinical Convention in Las Vegas, November, 1966.

Historically, the term "ethical" has been used to refer to matters involving moral principles or practices, customs, and usages of the medical profession and matters of policy not necessarily involving issues of morality in the practice of medicine. The term "unethical" has been used to refer to conduct which fails to conform to those professional standards, customs, and usages or policies, as interpreted by the AMA. In its report, the Judicial Council stated that unethical conduct involving moral principles, values and duties calls for disciplinary action such as censure, suspension or expulsion from medical society membership.

Failure to conform to the customs and usages of the medical profession may call for disciplinary action depending on the particular circumstances involved, local attitudes, and how the conduct in question may reflect upon the dignity of and respect for the medical profession. In matters strictly of a policy nature, a physician who disagrees with the position of the AMA is entitled to freedom and protection in his point of view.

EXAMPLES

1. *What kind of information can you release to the press without your patient's consent?*

According to the AMA's Judicial Council's statement, certain information in the public domain can be made available without the patient's consent. News in the public domain includes births, deaths, accidents, and police cases. The Council has listed the following areas of news which are considered to be in the public domain and which can be made available without the patient's consent:

- Personal information: Name, address, age, sex, race, marital status, employer, occupation, name of parents in case of births, name of next-of-kin in case of deaths.
- Accidents: General information, such as back injuries or internal injuries. However, circumstances surrounding shootings, knifings, poisonings, and others are police matters, but statements may be made to the effect that the patient was injured by a knife or other sharp instrument.
- Diagnosis: No statement should be made by or on behalf of the attending physician. The same holds true for making a prognosis.

(Continued on page 846)

WHEN **ANXIETY** IS A SIGNIFICANT COMPONENT OF THE CLINICAL PROFILE

LIBRIUM® (chlordiazepoxide HCl)

Also available as
LIBRITABS™ (chlordiazepoxide)
5-mg, 10-mg, 25-mg tablets



Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver-function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

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Medical Ethics (Continued from page 844)

- Condition: General condition may be reported using the classifications of minor injuries or similar general diagnosis—good, fair, serious, or critical.

The Judicial Council report concluded: "Doctors of medicine are ethically and legally required to protect the personal privacy and other legal rights of the patients. The doctor-patient relationship and its confidential nature must be maintained. With these considerations in mind, the physician may assist the representatives of these media in every way possible.

2. *A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.*

- Standards, Usefulness, Non-Sectarianism: In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma, or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought." A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated ac-

tivities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training, and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice. (Principles of Medical Ethics, 1955 edition, Chapter II, Section 1.)

- Defining "Physician": A physician is one who has acquired a contemporary education in the fundamental and special sciences, comprehended in the general term "medicine" used in its unrestricted sense, and who has received the degree of Doctor of Medicine from a medical school of recognized standing. (House of Delegates, 1924.)

- Defining "Sectarian": A sectarian, as applied to medicine, is one who in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and experience. (House of Delegates, 1924.)

Ethical Relations Committee

Willard C. Scrivner, *Chairman*

J. Ernest Breed

William M. Lees

Burtis E. Montgomery

Mather Pfeifferberger

"If a psychiatrist were to diagnose appendicitis on the basis of psychologic examination alone, he would justifiably be criticized. Yet many physicians are quite willing to diagnose a psychoneurosis on the basis of physical examination alone. But the patient with psychiatric problems has no protrusions, tumors, points of tenderness, chills or fever. He has no symptoms that can be seen in the usual medical sense; his problems can only be heard.

When the physician is asking questions about a physical illness, he reasonably expects correct answers. The psychiatric patient, however, gives distorted responses and may completely withhold many important facts. Unfortunately, our contemporary culture dictates that others must have a good opinion of us, and this dictum is painfully true in the relationship between patient and physician. Many patients have an inordinate need to portray themselves as normal. Price M. Cobbs: *Psychiatric Problems in Office Practice*, Postgrad. Med. (Mar.) 1967, 41:3 pp. A-93-96.

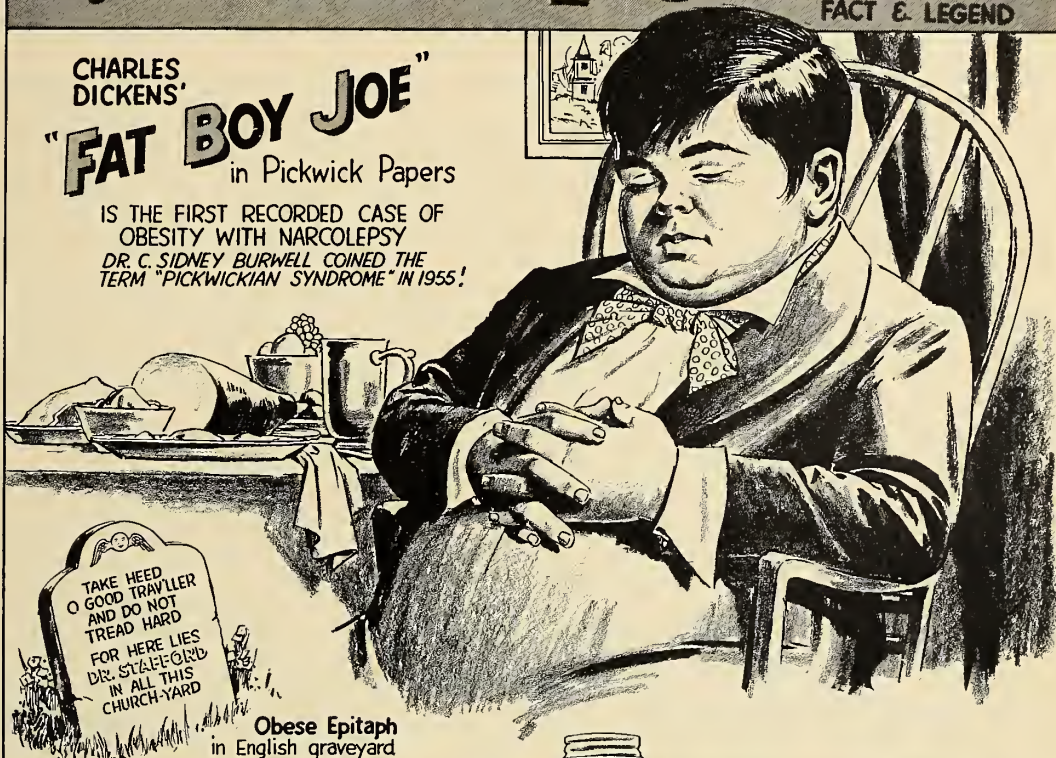
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of

Obesity Oddities

FACT & LEGEND

CHARLES DICKENS' "FAT BOY JOE" in Pickwick Papers

IS THE FIRST RECORDED CASE OF
OBESITY WITH NARCOLEPSY
DR. C. SIDNEY BURWELL COINED THE
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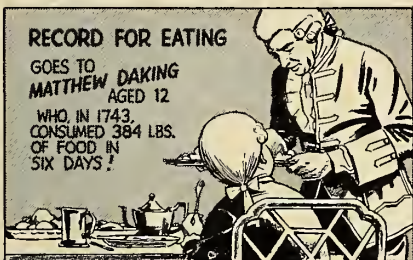


TAKE HEED
O GOOD TRAVELLER
AND DO NOT
TREAD HARD
FOR HERE LIES
DR. STAFFORD
IN ALL THIS
CHURCH-YARD

Obese Epitaph
in English graveyard

RECORD FOR EATING

GOES TO
MATTHEW DAKING
AGED 12
WHO IN 1743
CONSUMED 384 LBS.
OF FOOD IN
SIX DAYS!



THE Cost of AMBAR EXTENTABS

IS APPROXIMATELY
ONE-HALF THAT OF
OTHER LEADING
APPETITE
SUPPRESSANTS.



AN IMPORTANT FACTOR
IN LONG-TERM THERAPY!

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting. Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming)

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A-H ROBINS

The Doctor's Library

CARDIAC SURGERY. By John C. Norman, M.D. The Appleton-Century Crofts Company, New York, New York, 1967, 603 pages, \$9.75.

The purpose of this multi-authored synopsis of cardiac surgery is to present "in brief usable form, a series of points of view." The 56 contributors do this clearly and concisely. Many phases of heart surgery including basic physiology, anatomy, diagnosis and therapy are incorporated into each section.

Section I deals with cardiopulmonary physiology, anesthesia, bypass and perfusion techniques. Recent advances are included in the discussion in this section. The bibliographies are current and pertinent. This section is recommended for those interested in cardiac surgery.

Sections II and III cover cardiac surgery in infants, children and adults. Problems in diagnosis and treatment are presented in a logical orderly manner. One minor drawback is the repetition and overlapping of the chapters on congenital heart disease. Otherwise these two sections of the book outline rather completely, available techniques for evaluation and surgery of congenital and acquired heart disease.

Complications of cardiac surgery are dealt with in section IV. The information in this section has practical application for surgeons caring for those diseases. Methods of handling problems in shock, infection and clotting abnormalities are clearly presented.

The final section presents recent developments in transplantation of the heart, assisted circulation and artificial prostheses. These topics point to the future of cardiac surgery and thereby complete the editors' purpose to present "a concise cross-sectional sampling of multidisciplinary thinking in contemporary cardiac surgery."

J. Conn, Jr., M.D.

Society Re-elects Dr. Ensrud

E. Richard Ensrud, M.D., Urbana, has been re-elected president of the Illinois Society of Internal Medicine. Also re-elected at the society's ninth annual meeting in May were Wright R. Adams, M.D., Chicago, president-elect, and Mervin Shalowitz, M.D., Skokie, secretary-treasurer.

James F. Feffer, M.D., Washington, D.C., president of the American Society of Internal Medicine, was the principal speaker.

Tandearil® oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Mild mood depression, poor appetite, little interest in the present or future. Does this picture mean that she's giving in to functional fatigue?

When functional fatigue is part of her problem, Alertonic can help counteract accompanying apathy and inertia. It helps lift mood, stimulate appetite, and establish new interest in daily life.

Pleasant-tasting Alertonic combines pipradrol hydrochloride—a gentle cerebral stimulant—with an excellent vitamin and mineral formula, in a satisfying 15% alcohol vehicle.

Especially in the aging patient, nothing fosters confidence and a sense of well-being better than your own personal warmth, understanding, and encouragement. Between visits, however, your prescription for Alertonic can help keep your patient from giving in to functional fatigue.

Adequate dosage is important: Prescribe Alertonic—one tablespoonful t.i.d., 30 minutes before meals ...tastes best chilled.

And for your patient's sake, prescribe Alertonic in the convenient, economical one-pint bottle.

Available only on prescription
Alertonic[®]

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%, pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B₁) (10 MDR*), 10 mg.; riboflavin (vitamin B₂) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B₆), 1 mg.; niacinamide (5 MDR), 50 mg.; choline,† 100 mg.; inositol,† 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.

†The need for these substances in human nutrition has not been established.

Indications: 1. Functional fatigue such as that often associated with: a depressing experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive compulsive states.

Side effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215

July Clinics for Crippled Children

Twenty-five clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will count 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social, and nursing service. There will be four special clinics for children with cardiac conditions and rheumatic fever, and two for children with cerebral palsy. Clinicians are selected from among private physicians who are certified Board members. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

July 5, Hinsdale—Hinsdale Sanitarium

July 6, Flora—Clay County Hospital

July 6, Peoria Cerebral Palsy (A.M.)—Roosevelt School

July 6, Sterling—Community General Hospital

July 11, East St. Louis—Christian Welfare Hospital

July 11, Peoria General—Children's Hospital

July 12, Champaign-Urbana—McKinley Hospital

July 12, Joliet—St. Joseph's Hospital

July 13, Springfield General—St. John's Hospital

July 13, Cairo—Public Health Building

July 14, Chicago Heights Cardiac—St. James Hospital

July 18, Quincy—St. Mary's Hospital

July 19, Mt. Vernon—Good Samaritan Hospital

July 19, Evergreen Park—Little Company of Mary Hospital

July 19, Rockford—St. Anthony's Hospital

July 20, Decatur—Decatur & Macon Co. Hospital

July 20, Elmhurst Cardiac—Memorial Hospital of DuPage County

July 25, East St. Louis—Christian Welfare Hospital

July 25, Peoria General—Children's Hospital

July 25, Danville—Lake View Hospital

July 26, Centralia—St. Mary's Hospital

July 26, Springfield Cerebral Palsy (P.M.)—Diocesan Center, St. Paul's Cathedral
815 South 2nd

July 26, Elgin—Sherman Hospital

July 27, Effingham Rheumatic Fever & Cardiac—St. Anthony Memorial Hospital

July 28, Chicago Heights Cardiac—St. James Hospital.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

In carrying on its program, the division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Editorial


(Continued from page 820)

Another cause of prolonged disability is an automobile accident (non-industrial) in which the employee has sustained bruises, a fractured toe, or whiplash injury. In time the worker recovers but his lawyer will not allow him to return until the trial is over. The employer is not to blame but continues to pay sick benefits until the litigation is settled.

Many amusing but costly incidents are uncovered by the medical director. One employee was asked why he did not return to work. "I feel fine, but I'm waiting for my doctor to return from a trip around the world. There is a question I want answered before I return to my job."

Many medical directors no longer accept a diagnosis of "nervousness" or an "emotional disturbance" as a cause of disability when it lasts more than three weeks unless the employee consults a psychiatrist. The industrial physician utilizes his only wedge with which he can accomplish this—he calls the personnel department and advises them to stop disability payments.

T. R. VAN DELLEN, M.D.
EDITOR



To help you relieve anxiety and tension

Serax[®]
(oxazepam)



Wyeth Laboratories

Philadelphia, Pa.

SAMA Takes Policy Positions On Matters Of Medical And National Interest

Representatives from 70 of the 82 member schools attended the recent 17th annual meeting of the Student American Medical Association, where the house of delegates, official policy-making body of the association, acted upon 50 resolutions and passed several which are of general national interest and thereby became SAMA policy:

1. "... in favor of medically supervised therapeutic abortion if requested by the patient and if the doctor, with the agreement of two other doctors, believe in its medical necessity; for example, that continuation of the pregnancy would endanger the life or health of the mother, that the pregnancy was the result of rape or incest, or that continuation of the pregnancy is likely to result in a grossly malformed child because of maternal infection (such of rubella), or because of the ingestion of drugs such as thalidomide early in pregnancy."

2. No position was taken with regard to the war in Vietnam but "... SAMA continues to support the policy of allowing physicians to fulfill their military obligation without actually being a member of the Armed Forces" by alternate service in the United States Public Health Service. Also, it was voted that female physicians could help fulfill the increasing needs of the military for physicians and the Armed Forces Medical Services and the USPHS were urged to liberalize their requirements with respect to female physicians with dependents.

3. With regard to house staff salaries, SAMA went "... on record as favoring a minimum salary of \$5,000 per year for interns and residents as one of the requirements for approval of intern and resident programs by the AMA in order to improve the quality of training and ease the financial burdens of house officers."

4. With regard to required prescribing of drugs in generic terms, the house endorsed "... in principle the freedom of physicians to prescribe drugs by trade name" and opposed legislation "... requiring that drugs

for Medicare and other patients under federally financed health programs be prescribed in generic terms ..."

5. Local SAMA chapters were encouraged to investigate "... the socio-economic problems of poor people in their communities, especially as these problems apply to health ..." and to initiate "community oriented activities ... to provide direct community service ... and to educate SAMA members on basic contemporary health problems ..."

Medic Alert Foundation Elects Dr. Christopherson

E. H. Christopherson, M.D., executive director of the American Academy of Pediatrics, has been elected to the board of directors of the Medic Alert Foundation International, Turlock, Cal.

Medic Alert is an international, nonprofit organization dedicated to educating and indoctrinating the medical profession and the public to the need for individuals with special or "hidden" health problems wearing a Medic Alert emblem on their person describing the condition. Each emblem carries the words "Medic Alert" and the staff of Aesculapius emblazoned in red enamel. The reverse side of the emblem contains one or more key words describing the individual's medical problem, the Foundation's telephone number and wearer's identifying number corresponding to an information card in the Medic Alert files. The foundation maintains a 24-hour a day central answering service to provide additional information on registrants in case of emergency, for physicians, public safety officials, and emergency hospital rooms. It is estimated that forty million Americans should wear some form of instantly recognizable informational device about their condition. The need is amplified by a highly mobile population.

Look how many ways

Thorazine®
brand of
chlorpromazine
can help

	Tranquilizer	Potentiator	Antiemetic
Agitation	●		
Alcoholism	●		●
Anxiety	●		
Cancer patients	●	●	●
Severe neurodermatitis	●		
Drug addiction withdrawal symptoms	●		●
Emotional disturbances (moderate to severe)	●		
Nausea & vomiting	●		●
Neurological disorders	●		
Obstetrics	●	●	●
Pain	●	●	●
Pediatrics	●	●	●
Porphyria	●	●	
Psychiatric disorders	●		
Hiccups—refractory	●		
Senile agitation	●		
Surgery	●	●	●
Tetanus	●	●	

'Thorazine' is useful as a specific adjuvant in the above named conditions.

The following is a brief precautionary statement. Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. **Contraindications:** Comatose states or the presence of large amounts of C.N.S. depressants. **Precautions:** Potentiation of C.N.S. depressants may occur (reduce dosage of C.N.S. depressants when used concomitantly). Antiemetic effect may mask other conditions. Possibility of drowsiness should be borne in mind for patients who drive cars, etc. In pregnancy, use only when necessary to the welfare of the patient. **Side Effects:** Occasionally transitory drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; mild fever; hypotensive effects, sometimes severe with

I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

Smith Kline & French Laboratories **SK & F**

Northwestern Scientists Locate Blood Clot-Dissolving Enzyme in Kidney Tissues

Two Northwestern University medical researchers have identified cells in the blood vessels of the human kidney that produce an enzyme that can dissolve blood clots in test tubes.

The enzyme has been found in human kidney cultures by Drs. Hau C. Kwaan, associate professor, and Maria B. Bernik, associate in medicine, of the Northwestern Medical School's department of medicine. Termed a "plasminogen activator," the enzyme may be related to a similar enzyme termed urokinase that is produced in urine.

The urokinase enzyme is now being tested clinically for treatment of occlusion (blocking) of lung arteries and peripheral veins in the legs, under a separate nationwide trial sponsored by the National Institutes of Health. It costs about \$1,000, according to Dr. Kwaan, to produce from about 100 gallons of urine enough urokinase to treat one case.

Drs. Kwaan and Bernik hope that their study may lead to an easier and cheaper way of producing a similar enzyme in living cells under artificial culture.

Drs. Kwaan and Bernik's "plasminogen activator" triggers a reaction in blood substance called plasminogen that produces plasmin, the actual protein-digester that dissolves blood clots.

Plasmin digests fibrin, the protein of blood clots. When you cut yourself and a clot forms, the clot contains fibrin. The plasmin released in your blood plasma removes the blockage by digesting the fibrin in the clot.

Drs. Kwaan and Bernik reported in an earlier paper that tissue studies reveal that the plasminogen activator is localized in the blood vessel cells of the kidney, especially in the cells of the small artery known as the vasa recta.

Now they have produced the substance in cultures obtained by biopsy and nephrectomy from human kidneys. Outgrowths from the transplanted human kidney tissue appeared in from one to four days. Fibrin-digesting action increased the longer the cells were cultured.

Their study is supported by the National Institutes of Health. The research was performed in two Northwestern-affiliated hospitals, the Veterans Administration Research Hospital, Chicago, and the Chicago Wesley Memorial Hospital.

The Doctor's Library

NURSES' HANDBOOK OF FLUID BALANCE. Norma Milligan Metheny, R.N., M.S., and William D. Snively, Jr., M.D., J. B. Lippincott Co., Philadelphia & Toronto, 1967, 279 pages. \$7.00.

This book describes the nurse's role in the problems of fluid imbalance. It is a clear, comprehensive, and well-illustrated handbook. Nurses will find the material useful in observing and interpreting the important areas of body fluid disturbances. The authors discuss body fluid disturbances as they relate to the surgical patient, the badly burned individual, and those with digestive, urologic, cardiac, endocrine, and respiratory diseases. Problems associated with drowning and exposure to heat are given consideration. Also presented is a chapter on body fluid imbalance problems in children. The book answers the questions of what to look for, how to look for it, and what to do about it.

T. R. Van Dellen, M.D.



Adaptation from
Shakespeare Rare Print
Collection

"Give me a bowl of wine
—in this I bury
all unkindness"

—SHAKESPEARE



DEAR DOCTOR:

Will Shakespeare was a pretty fair hostler and real estate investor, a pal of Francis Drake and Walter Raleigh, much admired by Queen Elizabeth, and a tophole poet and playwright—but no physician.

Nevertheless, he had a rather good idea of the helpfulness of wine in cases of stress, as you can see above.

Like Will, we wish to recommend a daily bit of wine, with your meals for your own personal stress, Doctor, in your rugged profession.

Also, for your wife's stress at home, we'd like to prescribe a 24-page folder, "WINE COOKERY THE EASY WAY," which will help her to relax in the kitchen (and help you at the bar-beque). We'll mail it to you (free) if you'll just drop us a note on your professional letterhead.

By the way, we'll also send you our newly revised 64-page booklet, "USES OF WINE IN MEDICAL PRACTICE," which summarizes a quarter century of scientific research, in America and Europe, as an aid to your profession.

We hope you will request one or both of these free booklets.

As you know, wine stimulates gastric flow; can help the convalescing patient; the patient lacking appetite; can help relieve anxiety; can help patients suffering from the malabsorption syndrome—and helps hospital and geriatric home morale. Shakespeare had a good idea there. And many physicians and hospital administrators are also sharing that idea.

Here's a toast in California wine, Doctor—to your health!

The Winemakers of California

WINE ADVISORY BOARD, 717 MARKET ST., DEPT 1, SAN FRANCISCO, CALIF. 94103

New Test Aids Diagnosis of Early Cases of Diabetes

The tolbutamide tolerance test may offer greater specificity than the standard 2-hour glucose test in diagnosing early diabetes, and a recent oral modification makes the tolbutamide test safer and more convenient without sacrificing reliability.

Clinicians at the University of Pennsylvania's Graduate Hospital made this assessment after a study of 105 patients, all of whom had normal fasting blood sugars but abnormal glucose levels two hours after a standard glucose tolerance test (GTT).

Fifty-two patients responded abnormally to the oral tolbutamide (Orinase) test. This correlated significantly with a family history of diabetes, and obstetrical history suggesting diabetes or patients with an elevated three-hour response to the GTT.

"We conclude that the oral sodium tolbutamide test seems to be a valuable additional study in the appraisal of minimally abnormal oral glucose tolerance results, at least in the presence of obesity, liver disease, hyperthyroidism, uremia, myocardial infarction, chronic pancreatitis, spontaneous hypoglycemia, and lymphomas and related neoplasia representing the major disease categories in our study group," said Drs. C. Robert Tittle and John H. Kerr.

While the intravenous tolbutamide tolerance test has been in use for some time, the Upjohn Company only recently received F.D.A. approval to market the oral tolbutamide test.

Patients in the group were selected from the wards in two general hospitals, excluding pregnant, postoperative, and unconscious subjects. Their ages ranged from 25 to 75.

In a report appearing in *Diabetes* (15: 212-219, March, 1966), the authors said a positive family history of diabetes showed up in 41 patients, of whom 35 (85.4%) responded abnormally to the oral tolbutamide test.

Out of 19 patients who were 20% or more over ideal weight, 10 had abnormal responses to oral tolbutamide. In each case, however, there was one or more associated findings suggestive of subclinical diabetes.

While patient groups by age decades were small, Drs. Tittle and Kerr said the

data seem to indicate that the percentage of abnormal tests was not significantly related to age.

The possibility of preventing symptomatic diabetes depends largely upon the earliest possible detection of the asymptomatic stage, and newer diagnostic techniques are designed to this end, they pointed out.

Reliability of a diagnosis of mild diabetes should be enhanced when both the GTT and the tolbutamide tests are positive. This does not imply, however, that a normal tolbutamide response positively rules out a diagnosis of diabetes in a patient with impaired glucose tolerance, the clinicians said.

They added that results in their study confirmed the opinion of other investigators that the tolbutamide test may be of greatest differential diagnostic value in the impaired glucose tolerance accompanying liver disease.

Bank Charge Cards

(Continued from page 824)

eliminates accepting the card and recording the fee after each visit, and allows the doctor to combine a number of charges on one billing slip.

Q. May a card holder authorize his dependents to use his charge privilege at a physician's office?

A. Yes, under a special pre-authorization procedure. The card holder signs a form directing his physician to service other "authorized" persons—including dependents—and to make out a single billing slip for the total charges in the patient's name.

Q. Should a physician agree to participate in a program, how would he introduce it to his patients?

A. He might want to send an announcement to his patients to explain the program. However, the AMA Judicial Council—according to *The AMA News* of Dec. 19, 1966—has recommended that the use of bank cards "in connection with payment of larger fees which might normally be paid to the physicians in installments should not be encouraged." The AMA has also said that doctors cannot be listed in directories of participating members and plaques within their offices indicating participation must be kept to a discreet and dignified minimum.

How to collect bills without sending them

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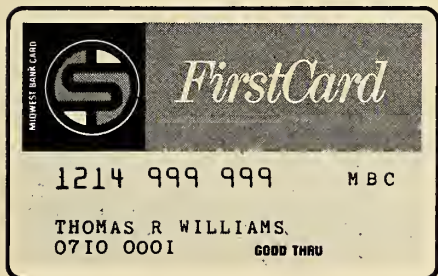
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*The
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gives relief in
15 minutes*

Each tablet contains:

Potassium Iodide.....195 mg.
Aminophylline.....130 mg.
Phenobarbital, Caution: May be habit forming... 21 mg.
Ephedrine HCl..... 16 mg.

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of
water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

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by Paul deHaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

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Combination Products—Consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

NEW SINGLE CHEMICALS

ATROMID-S Cholesterol reducing agent Rx
Manufacturer: Ayerst Laboratories

Nonproprietary Name: Clofibrate

Indications: Reduction in serum lipids in hypercholesterolemia and/or hypertriglyceridemia.

Contraindications: Impaired renal or hepatic function, during pregnancy and lactation. Not to be used in children.

Dosage: One capsule q.i.d.

Supplied: Capsules—500 mg.; bottles of 100.

DUPLICATE SINGLE PRODUCTS

AMPHICOL Antibiotics—B & M Spectrum Rx

Manufacturer: McKesson Laboratories

Nonproprietary Name: Chloramphenicol

Indications: Serious infections caused by organisms which are susceptible to it.

Contraindications: Not to be used for trivial infections such as colds, influenza, or infections of the throat, or as a prophylactic agent to prevent bacterial infections.

Dosage: Adults—50 to 100 mg/Kg./day in divided doses at 6 hour intervals.

Children—50 mg/Kg./day divided into 4 doses at 6 hour intervals.

Infants—25 mg/Kg./day divided into 4 doses at 6 hour intervals.

Supplied: Capsules—100 and 250 mg.; bottles of 100 and 1000.

DUPLICATE SINGLE PRODUCTS

KESSO-PEN Antibiotics—Penicillin Rx

Manufacturer: McKesson Laboratories

Nonproprietary Name: Potassium Penicillin G

Indications: Oral treatment for infections due to penicillin-susceptible organisms in both mild and moderately severe cases.

Contraindications: Known sensitivity to it.

Dosage: 200,000 to 500,000 units t.i.d. up to q. 3h.

Supplied: Tablets—200,000, 250,000 and 400,000 units; bottles of 100. Powder for Syrup—200,000 to 400,000 units; bottles of 16 and 30 doses.

DUPLICATE SINGLE PRODUCTS

POISON IVY Capsules Immunizing Agent Rx

Manufacturer: Broemmel Pharmaceuticals

Nonproprietary Name: Alcoholic extract of Poison Ivy leaves.

Indications: Prevention of dermatitis in indi-

viduals who are sensitive to contact with Poison Ivy plants.

Contraindications: Not for treatment of active cases of Poison Ivy dermatitis.

Dosage: One capsule t.i.d. after meals.

Supplied: Capsules—60 mg.; bottles of 100.

DULICATE SINGLE PRODUCTS

POISON IVY Elixir Immunizing Agent Rx

Manufacturer: Broemmel Pharmaceuticals

Nonproprietary Name: Alcoholic extract of Poisin Ivy leaves.

Indications: Prevention of dermatitis in individuals who are sensitive to contact with Poison Ivy plants.

Contraindications: Not for treatment of active cases of Poison Ivy dermatitis.

Dosage: One teaspoonful in water, t.i.d. after meals.

Supplied: Bottles of 3 fl. oz.

DUPLICATE SINGLE PRODUCTS

OP-SULFA-10 Sulfonamide Rx

Manufacturer: Broemmel Pharmaceuticals

Nonproprietary Name: Sodium sulfacetamide

Indications: Common infections of the eye and eye socket, acute and chronic blepharitis, blepharoconjunctivitis, conjunctivitis, keratoconjunctivitis and dacryocystitis. Also prophylactically following injuries and removal of foreign objects from the eye.

Contraindications: None mentioned.

Dosage: One to two drops, 2-3 times daily, depending upon the severity of the condition.

Supplied: 5 cc. glass dropper bottle—10% sol.
15 cc. plastic dropper bottle—10% sol.

DUPLICATE SINGLE PRODUCTS

OP-SULFA-30 Sulfonamide Rx

Manufacturer: Broemmel Pharmaceuticals

Nonproprietary Name: Sodium sulfacetamide

Indications: Common infections of the eye and eye socket, acute and chronic blepharitis, blepharoconjunctivitis, conjunctivitis, keratoconjunctivitis and dacryocystitis. Also prophylactically following injuries and removal of foreign objects from the eye.

Contraindications: None mentioned.

Dosage: One or two drops, 2-3 times daily, depending upon the severity of the condition.

Supplied: 5 cc. glass dropper bottle—30% sol.
15 cc. plastic dropper bottle—30% sol.

COMBINATION PRODUCTS

ORTHO-NOVUM, 1 mg. Progesterone/Estrogen Combination Rx

Manufacturer: Ortho Pharmaceutical Corp.

Composition:

Norethindrone	1.0 mg.
Mestranol	0.5 mg.

Indications: Oral contraception.

Contraindications: History of thrombophlebitis or pulmonary embolism, liver dysfunction or disease, known or suspected carcinoma of the breast or genital organs, undiagnosed vaginal bleeding.

Dosage: One tablet daily for 20 days, beginning on day 5 of the menstrual cycle.

Supplied: Dialpak Dispenser—20 and 60 tablets.
Tare-Pak Dispenser—20 tablets. Bottles—500 tablets.

COMBINATION PRODUCTS

PROCTOFOAM Hemorrhoidal Preparation Rx

Manufacturer: Reed & Carnrick

Composition:

Pramoxine HCl. 1%
Hydrocortisone acetate 1%



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
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...adsorbs irritants with kaolin, and protects
intestinal mucosa

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.



Parepectolin®

Each fluid ounce of creamy white suspension contains:

Paregoric (equivalent)..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.

warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Children's Dose: One or two teaspoonfuls three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

Indications: Proctological conditions that could benefit from an analgesic, anti-inflammatory, mucoadherent preparation.
Contraindications: None mentioned.
Dosage: Not specified.
Supplied: Aerosol container with plastic applicator that delivers measured amounts.

COMBINATION PRODUCTS

ROBITUSSIN-PE Cough Preparation o-t-c
Manufacturer: A. H. Robins Co. Inc.

Composition:
 Each 5 cc. contains:
 Glyceryl guaiacolate 100 mg.
 Phenylephrine HCl. 10 mg.
 Alcohol 1.4%

In a cherry-nut flavored syrup.

Indications: Temporary relief of nasal congestion and cough due to the common cold, paranasal sinusitis, or other upper respiratory illnesses.

Contraindications: Hypersensitivity to glyceryl guaiacolate or sympathomimetic amines, marked hypertension, or patients who are receiving MAO inhibitors.

Dosage: Adults—one tsp. every 3-4 hours.
 Children (6-12 years)—one-half to one tsp. q. 4h.

Children (3-6 years)—one-fourth to one-half tsp. q. 4h.

Supplied: Bottles of one pint and one gallon.

COMBINATION PRODUCTS

THEOKIN ELIXIR Bronchodilator Rx
Manufacturer: Knoll Pharmaceutical Co.

Composition:
 Theophylline calcium salicylate 149.5 mg.
 Potassium iodide 150.0 mg.
 Alcohol 9.5%
 Mint flavored

Indications: Symptomatic treatment of bronchial asthma, chronic bronchitis, and chronic obstructive pulmonary emphysema, when reversible bronchospasm and thickened mucous secretions can be demonstrated.

Contraindications: Peptic ulcer and gout.

Dosage: Adults—1 tbsp. two or three times daily.

Children—(6 to 12 years)—1 tsp./30 lbs. body weight once or twice daily.

Children (under 6 years)— $\frac{1}{2}$ tsp./15 lbs. body weight, once or twice daily.

Supplied: Pint bottles.

Diagnosis Journal Started

The first issue of *Diagnostica*, a bi-monthly journal devoted solely to medical diagnosis, has been published by Ames Co., Division Miles Laboratories, Inc., Elkhart, Ind. Appearing in seven different language editions, *Diagnostica* will report advances in presymptomatic detection, diagnosis, and management of disease and metabolic disorder.

According to Ames, *Diagnostica* is the first medical journal devoted solely to diagnosis in the practice of medicine. Each issue will describe new diagnostic concepts and practices and review established procedures. It will encourage the use of clinical measuring instruments for multiphasic diagnostic screening, patient management, and presymptomatic detection of human diseases and disorders.

Diagnostica is being distributed worldwide to physicians in private practice and on hospital staffs who are general practitioners, internists, obstetricians and gynecologists, pediatricians, urologists, and pathologists. It will also go to interns and to residents in these specialties, as well as to osteopaths.

Each issue will include an article of major importance and an invited article by an authority in a field such as urology, hematology, or pathology. The first issue contained a major article "Lipid Metabolism in Diabetes" and an invited article on "Infectious Hepatitis" by Alexander Paton, M.D., M.R.C.P., Dudley Road Hospital, Birmingham, England. Topics scheduled for future issues include malaria, azotemia and computers in diagnosis. Invited articles will cover potassium depletion, tuberculosis, saliva as a diagnostic aid.

Pictoclinic, previously a separate publication, is now a department in *Diagnostica*, and will illustrate selected diagnostic methods. Other features include "Diagnostic

(Continued on page 866)

COOK COUNTY

Graduate School of Medicine CONTINUING EDUCATION COURSES

Starting Dates—1967

SPECIALTY REVIEW COURSE IN SURGERY, Part I, August 14
 SPECIALTY REVIEW COURSE IN MEDICINE, Part I, Sept. 11 & 25

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PRINCIPLES OF OPERATIVE SURGERY, Two Weeks, July 24

BASIC PRINCIPLES IN GENERAL SURGERY, Two Weeks, July 10

SURGERY OF THE HAND, One Week, September 18

SURGERY OF THE STOMACH, One Week, September 18

SURGERY OF FACE, MOUTH & NECK, One Week, September 18

VAGINAL APPROACH TO PELVIC SURGERY, One Week, September 18

ADVANCES IN GYNECOLOGY & OBSTETRICS, One Week, September 25

CLINICAL ENDOCRINOLOGY, One Week, June 26

BASIC ELECTROCARDIOGRAPHY, One Week, October 9

ADVANCES IN PEDIATRICS, One Week, September 25

PEDIATRIC SURGERY, One Week, September 25

DIAGNOSTIC RADIOLOGY, One Week, September 18

ANESTHESIA, Inhalation, Endotracheal, Regional, Request dates

Information concerning numerous other continuation courses available upon request.

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Cook County Hospital

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Antidote For Pesticide Poisoning

A tested and specific antidote for pesticide poisoning—an increasing danger in the United States—is now available on prescription according to Ayerst Laboratories, of New York. The announcement was made in connection with the annually held National Poison Prevention week, an activity of the United States Public Health Service.

This antidote, called Protopam® Chloride (pralidoxime chloride), has been lifesaving when used with atropine and other medical measures. It is also known as 2-PAM. Protopam Chloride is useful for treating the harmful, and sometimes lethal, effects of parathion, malathion, and other pesticides and chemicals of the organophosphate class. Such pesticides are widely used in dusts or sprays for the farmer and occasionally for the home gardener. Serious exposure may occur through carelessness, faulty equipment, or an abrupt change in weather conditions. Pesticides rank fifth among harmful substances most frequently ingested by young children. In 1965, the National Clearinghouse for Poison Control Centers received 3,856 reports of children under five who had ingested pesticides by accident.

Protopam Chloride has been found to be effective clinically against the following pesticides: parathion, diazinon, malathion, Phosdrin,® and TEPP. Animal studies indicate that it will prove to be effective clinically against many other related compounds. Protopam Chloride is active when administered intravenously, intramuscularly, or orally.

Treatment of pesticide poisoning, authorities emphasize, is most effective when it is begun immediately. The longer the delay, the greater the potential danger. At least in the case of parathion, little will be accomplished if the drug is administered more than 36 hours after exposure has occurred.

In mild cases, the symptoms are headache, blurred vision, sweating, lacrimation, salivation, diarrhea, and tightness in the chest. A severe case may show, in addition, cyanosis, respiratory embarrassment, and coma. Protopam Chloride is supplied in three forms: an emergency kit containing a sterile syringe and needle for single dose intravenous injection, a multiple unit hospital package, and tablets.

R

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North Shore Hospital, a 65-year-old psychiatric facility located on Lake Michigan in Winnetka, Illinois, is an intensive care hospital.

An open staff institution, it provides, through its house and attending staff, a total range of psychotherapies and those related activities which round out a comprehensive treatment program.

A new Half Way Hall, situated in the hospital, has been opened to provide relative freedom of movement in an environment designed to stimulate recovery and provide a necessary phase of interim residence.

A completely open section is a feature of North Shore Hospital's residential plan.

An adolescent program offers boys and girls of high school age a closely-structured program of daily care, with daily classroom attendance and individual tutoring emphasized.

The adjunctive therapies are manned by certified personnel. Occupational and recreational activities not only help structure the patient's day, but offer creative programs in which patients participate according to their emotional health and native capacity.

A therapeutic education program has been introduced for all patients. Medicare patients are offered special attention and remotivation activities.

Psychiatric testing and evaluation is offered, as is individual and group therapy, chemotherapy and the traditional modalities employed in the treatment of emotional illness.

In reputation, performance and location, North Shore Hospital is the psychiatric hospital of choice.



For information, contact:
CHARLES H. JONES, M.D.
Superintendent & Psychiatrist in Chief
Telephone: 312-446-8440
225 Sheridan Road, Winnetka, Illinois
(Write for Brochure)

Diagnosis Journal

(Continued from page 864)

Conference," a composite case drawn from actual hospital files, and "Facts with Figures," a feature on medical statistics.

"Tales of Medical Detection" in each issue will show how medical diagnosis has aided solution of mysteries. The first issue reprints a classic in the field—"Eleven Blue Men," by Berton Roueche, detailing investigations in New York City which traced eleven cases of sodium-nitrite poisoning to one salt shaker in one small restaurant.

Diagnostica will be published in English, French, German, Italian, Spanish, Portugese and Japanese editions to reach practicing physicians in all countries.

Ames Company, Division Miles Laboratories, Inc., is a leading manufacturer of diagnostic aids and electronic instruments, laboratory supplies and laboratory equipment. Ames products are marketed in 84 countries.



NEW BUFFERED SURGICAL SCRUB

A new, high-efficiency surgical scrub, buffered to maintain maximum antibacterial action even at 50 to 1 dilutions, has been announced by the S. M. Edison Chemical Co., New York. The company also manufactures and distributes Dermassage. Introduction of Derma Surgical follows intensive national testing in hospital operating rooms, nurseries, obstetrical and surgical wards. Derma Surgical is a clear aquamarine liquid that combines the germicidal power of hexachlorophene with the soothing action of Dermassage lotion. It is available in four-ounce, eight-ounce, and 1-gallon sizes.

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OBITUARIES

***Dr. Ernest G. Beatty**, Pontiac, died March 21 at the age of 81. He opened his practice in Pontiac in 1916 and was appointed assistant physician at the Pontiac Reformatory in 1918, continuing this work along with his private practice. A past president of the Livingston County Medical Society and a member of the ISMS Fifty-Year Club, he was on the staff of St. James Hospital in Pontiac.

Dr. Morris R. Carter died April 13 at the age of 73. He had practiced medicine on the south side of Chicago for 30 years and was known for his charitable work. He was a member of the Cook County Physicians Association and Alpha Phi Alpha Fraternity.

***Dr. Frederick Christopher**, died May 21 at the age of 77 in Seattle. He was an Evanston Hospital staff member for 32 years before retiring in 1954, professor of surgery at Northwestern University and a member of the ISMS Fifty-Year Club. He was the author of several books and more than 100 articles.

***Dr. Alphon L. Cornet** died May 22 at the age of 81. He was on the staff of St. James Hospital, Chicago Heights, and a member of the ISMS Fifty-Year Club.

***Dr. Joseph T. Coyle**, Chicago, died April 22 at the age of 62. He was the team physician for the Chicago White Sox and also served as chief of orthopedics at Mercy Hospital.

***Dr. Oleh Dorozynsky**, South Holland, died May 17 at the age of 44. He was a member of the Ukrainian Medical Society of Chicago and a staff member at Ingalls Memorial Hospital in Harvey.

***Dr. Lester Harper Hills**, Elmhurst, died May 17. He had practiced in Elmhurst since 1919 and since 1920 had been a surgeon for the Chicago and North Western Railway. A past president of the Du Page County Medical Society, he was a member of the ISMS Fifty-Year Club.

Dr. Lillian Humphrey, Coral Gables, Fla., died April 21 at the age of 47. A graduate of the Chicago Medical School, Mrs. Humphrey was a board member of the Illinois Opera Guild and a member of the Alliance Francaise.

***Dr. Maurice H. Judd**, River Forest, died May 26 at the age of 59. He was on the staff of Gottlieb Memorial Hospital, Melrose Park, and Walther Memorial Hospital, Chicago.

***Dr. Charles J. LaHodney**, Evergreen Park, died April 22 at the age of 87. He was a general physician and surgeon who had practiced for 64 years. He was one of the founders of Roseland Community Hospital and once served as its president.

***Dr. Shirley W. Lane**, past president of the Kankakee County Medical Society, died April 15 at the age of 59. He had been a Kankakee physician for 21 years and was on the staffs of Riverside and St. Mary's Hospital. He was a graduate of the University of Illinois Medical School and was a navy veteran of World War II.

***Dr. Reubin R. Lisse**, Chicago, died April 7 at the age of 61. He practiced at Roseland Community Hospital for 30 years and was a veteran of World War II.

Dr. William A. Loeppert, Oak Park, died April 2 at the age of 56. He was a practicing physician for 30 years and was on the staffs of Ravenswood and Oak Park Hospitals.

***Dr. Arthur F. McAuley**, Chicago, died May 5 at the age of 67. He was a member of the staff at Belmont Community Hospital for 30 years.

***Dr. David V. Omens**, a dermatologist formerly on the staff of Cook County Hospital, died May 17 in Chicago. A member of the ISMS Fifty-Year Club, Dr. Omens was 80.

***Dr. Verdamae Karr McKee**, Sidell, died April 12 at the age of 50. She practiced in Sidell for the past three years and was a member of the staff at the Veterans Administration Hospital in Danville. She was known for her work in mental hospitals and was the first woman to head a major state institution. In 1958, she became superintendent of the Dixon State School on an appointment by the governor.

***Dr. J. B. Schreiter**, Savanna, died March 16 at the age of 92. A past president of the Carroll County Medical Society and a member of the ISMS Fifty-Year Club, Dr. Schreiter was elected Carroll County Coronor in 1900 and served in that office for 48 consecutive years. In 1951 he was named "Illinois General Practitioner of the Year" as the state's outstanding family physician.

Dr. C. K. Smith, died April 15 at the age of 83. He formerly served as Kankakee Health officer for 47 years.

(Continued on page 870)

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Obituaries

(Continued from page 868)

***Dr. Emil J. Stein**, 77, died May 7 in Oak Park. He was a captain in the Navy Medical Corps Reserve, having served in World War I and II, and former associate professor of anatomy and surgery at the University of Illinois. He was also a member of the ISMS Fifty-Year Club.

***Dr. Floyd G. Tindall**, past president of the Winnebago County Medical Society and a member of the ISMS Fifty-Year Club, died March 22 in Winter Haven, Fla. He was 79.

***Dr. Henry H. Wegert**, Chicago, died April 9 at the age of 86. He was a graduate of Loyola University Medical School and a member of the ISMS Fifty-Year Club.

Dr. Jacob A. Wertschnig, Skokie, died April 23 at the age of 40. He was a resident physician for five years at the Veterans Administration Research Hospital in Chicago.

***Dr. King G. Woodward**, Rockford, died April 12 at the age of 69. A past president and secretary of the Winnebago County Medical Society, he also served terms as president of the staff of Rockford Memorial Hospital and was chairman of the hospital's pediatrics staff.

**Member, Illinois State Medical Society.*

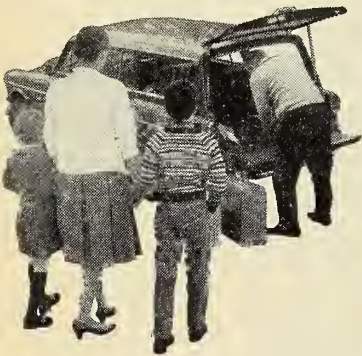
Meeting Memos

June 26-28—Children's Hospital of Denver will conduct its spring clinic at Vail, Colo. Advances in Pediatrics and the Path Ahead in Pediatric Practice will be featured.

June 30-July 5—Mid-summer meeting of International College of Surgeons will be held at Mont Gabriel Lodge, Quebec, 30 miles from "Expo 67," the Montreal fair.

July 14-15—The Rocky Mountain Cancer Conference at the Brown Palace-West Hotel, Denver, Colo., will feature Dr. Milford O. Rouse, president of the American Medical Association, and Dr. Ashbel C. Williams, president of the American Cancer Society, and other distinguished speakers on the subject of cancer.

Aug. 9-13—Sixth annual Lawyers and Physicians Conference at Lake Junaluska, N.C., will have as its theme, "Is Jesus Christ Relevant in Modern Medicine and Law?"



Vacation trip....

Motion sickness?



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Illinois Medical Journal

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